

DIocese of Lansing and St. Andrew Catholic Religious Education
HEALTH HISTORY AND MEDICAL RELEASE FORM
FOR PARISH PROGRAM AND ACTIVITIES

Participants Name _____ Sex _____ Birth Date _____ Age _____

Parent/Guardian Name _____ Relationship to participant _____

Street Address _____ City _____ Zip _____

Home Telephone (____) _____ Cell/Work Telephone (____) _____

Student's Grade: _____ Grad. Yr. 20 Day Attending: _____ Time Attending: _____

HEALTH HISTORY

Family Doctor _____ Phone: (____) _____

Family Dentist _____ Phone: (____) _____

IMMUNIZATIONS up to date? **YES** _____ **NO** _____ (if **NO**, record **YEAR** of last immunization or last time person had disease)

Tetanus/Diphtheria _____	Measles _____	Mumps _____
Chicken Pox _____	Rubella _____	Polio _____
TB _____ (results) _____	Other _____	Hepatitis B _____

SPECIAL INFORMATION

Information will be shared on a "need to know" basis with appropriate staff/volunteers only

CONDITION(S) (please check all that apply and describe them below)

Allergies _____	Fainting Spells _____	Seizures _____
Asthma _____	Frequent Colds _____	Severe Headaches _____
Blackouts _____	Frequent Earaches _____	Severe Homesickness _____
Diabetes _____	Frequent Nosebleeds _____	Other _____
Dizziness _____	Kidney Problems _____	Other _____

DESCRIPTION: _____

MEDICATIONS: Is your child taking any medication? _____ If yes, list name of medication(s), frequency and dosage: _____

AIDE: Does your child require an aide? _____ If yes, explain: _____

Is the aide needed full time? _____ or part-time? _____ other? _____

HEALTH HISTORY AND MEDICAL RELEASE FORM (CONTINUED)

LIMITATIONS: Does your child have any **PHYSICAL LIMITATIONS**? _____ If yes, please describe. _____

Does your child have any **EMOTIONAL/PSYCHOLOGICAL LIMITATIONS**? _____ If yes, please describe. _____

Does your child have a **LEARNING DISABILITY**? _____ If yes, please describe. _____

EMERGENCY INFORMATION

In an **EMERGENCY**, and if unable to reach parent/guardian, we should contact:

- 1) Name _____ Phone (_____) _____
2) Name _____ Phone (_____) _____

PERMISSION FOR MEDICAL TREATMENT

In case of **EMERGENCY**, I hereby give permission to transport my child to the nearest hospital/emergency center for medical or surgical treatment. I will be contacted as soon as possible and will be advised prior to any further treatment by the hospital or doctor.

Signature: _____ Date: _____

Family Insurance Provider _____

Health Plan Number _____ Expiration Date: _____

**** IMPORTANT ****

**If your child's medical condition changes,
it is your responsibility to contact the parish office
so that we can update medical information.**

This form is effective June 1, 2011 – October 1, 2012

(over)