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?____________________

(over)

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, 2010 – October 1, 2011

(over)