

***St. Mary Faith Formation/Religious Education
Health History and Medical Release Form 2010-2011***

Participant's Name _____ Sex ___ Birthdate _____ Grade _____
Parent/Guardian _____ Relation to Participate _____
Street Address _____ City _____ Zip _____
Home Phone Number _____ Work Phone Number _____
Family insurance/health plan _____ Health Plan Number _____

Health History

Family Physician _____ Phone Number _____

Immunizations (Record year of last immunization or last time participant had disease)

Tetanus/diphtheria _____ Measles _____ Mumps _____
Chicken Pox _____ Rubella _____ Polio _____
TB (results) _____ Other _____

Special Information

Please check all that apply. Information will be held in strict confidence.

Sleep Walking _____ Fainting _____ Dizziness _____
Blackouts _____ Asthma _____ Kidney Problems _____
Frequent Nosebleeds _____ Frequent Colds _____ Seizures _____
Severe Headaches _____ Severe Homesickness _____ Diabetes _____

Allergic Reactions

Please list all known allergies – plant, insect, food, medicine AND the reaction.

Please indicate any other medical problems/situations pertinent to your child.

Any physical limitations? _____ If yes, explain: _____

Any emotional/psychological limitations or reactions to be aware of? _____ If yes, explain: _____

Is the student presently taking any medication? _____ All medication is to be well labeled with clear, concise directions indicated here (frequency, dosage, etc.) _____

In an emergency, and unable to reach parent or guardian, contact:

1. Name _____ Telephone _____

2. Name _____ Telephone _____

Please read the following sections over carefully.

We apologize for the complexity but we must be sure we have your full consent in these areas as well.

Permission for Routine Medical Treatment:

All attempts will be made to notify you if your child requires medical treatment (i.e., cases of high, persistent fever: severe vomiting, etc.) Please indicate whether or not you wish attempts to be made to contact you if your child becomes ill with minor symptoms (i.e., headache, sore throat, low-grade fever, etc.)

Yes _____ No _____

We do not wish to give any medical treatment to your son/daughter against your wishes:

- A. I grant permission for the non-prescription medication (i.e. Tylenol, cough syrup, etc) except for the following _____ to be given my child if deemed advisable by the designated supervisor, and I grant permission for routine non-surgical medical care to be given to my child, if deemed advisable by the designated supervisor(s).

Signature _____ Date _____

- B. I do not want ANY type of medication administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature _____ Date _____

Permission for Emergency Medical Treatment

In case of emergency, I hereby give permission to transport my child to the nearest hospital/emergency center for emergency 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 _____

Notes: