**HEALTH HISTORY AND MEDICAL RELEASE FORM FOR PARISH PROGRAMS AND ACTIVITIES**

Participant’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex \_\_\_ Birth date \_\_\_\_\_\_\_\_\_ Grade \_\_\_\_ Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_\_\_ Home phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_

 **HEALTH HISTORY**

Family Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNIZATIONS** (Record YEAR of last immunization, or last time person had disease. If unsure of dates may also mark with a “UTD” for “Up To Date”).

 Tetanus/Diphtheria \_\_\_\_\_\_\_\_ Measles \_\_\_\_\_\_\_\_ Mumps \_\_\_\_\_\_\_\_ Chicken Pox \_\_\_\_\_\_\_ Rubella\_\_\_\_\_\_\_\_\_

Polio \_\_\_\_\_\_\_\_\_\_ TB \_\_\_\_\_\_\_(results) \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_ Hepatitis B \_\_\_\_\_\_\_\_\_

**SPECIAL INFORMATION:** (Please check all that apply. Information will be shared on a “need to know” basis or shared with appropriate staff. )

Sleep Walking \_\_\_\_\_ Fainting \_\_\_\_\_\_\_ Dizziness \_\_\_\_\_\_\_\_\_Blackouts \_\_\_\_\_ Asthma \_\_\_\_\_\_\_\_\_\_\_Kidney Problems \_\_\_\_\_\_\_\_\_ Frequent Nosebleeds \_\_\_\_\_\_\_\_ Frequent Colds \_\_\_\_\_\_\_\_\_\_\_\_ Seizures \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Severe Headaches \_\_\_\_\_\_\_\_\_\_ Severe Homesickness \_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_\_Frequent Earaches \_\_\_\_\_\_\_\_\_\_

**ALLERGIC REACTIONS**  (Please list all known allergies - plant, insect, food, medicine AND TYPE OF 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? \_\_\_\_\_\_\_\_ If so please indicate which medication below. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAMILY INSURANCE PROVIDER/HEALTH PLAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEALTH PLAN NUMBER (Include expiration date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_