

Faith Formation of Youth and Young Adults Medical Form

Health Form and History

****Please enclose a copy of medical card/insurance information****

Participant's Name _____ Sex _____
Parish _____
Town/City _____ State _____
Birth Date _____ Age _____
Parent or Guardian _____
Relationship to Participant _____
Street Address _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____
Family Doctor _____ Phone _____

Immunizations: Record year of last immunization for the following:

Tetanus/Diphtheria _____ Measles _____
Mumps _____ Chicken Pox _____
Rubella _____ Polio _____

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

Sleep Walking _____ Asthma _____ Kidney Problems _____
Fainting _____ Frequent Nosebleeds _____ Frequent Colds _____
Dizziness _____ Seizures _____ Severe Headaches _____
Blackouts _____ Diabetes _____ Homesickness _____
Frequent Earaches _____ Heart Problems _____ Depression _____
Other _____ Please explain. _____

Allergic Reactions: Please list all known allergies: plant, insect, food, medicine, etc. Indicate **type of reaction** and **treatment**: _____

Does your child require an Epipen? Yes ___ No ___ If you have answered "yes" please make sure that your child has an Epipen with him/her at all times. He/She will be responsible for administering treatment.

Please indicate any other **medical problems/conditions**: _____

Any physical limitations? Yes _____ No _____ If yes, please explain.

Any emotional/psychological limitations or reactions to be aware of? Yes _____ No _____
If yes, please explain. _____

Please note that adult chaperones are not allowed to dispense medications.

Is this participant presently taking any medication? Yes _____ No _____

All medication is to be well labeled with clear, concise directions indicated on lines below. Medicine must be in original bottle from pharmacy. Please keep medicines in their original, labeled containers. Bring copies of your prescriptions and the generic names for the drugs. If a medication is unusual or contains narcotics, carry a letter from your doctor attesting to your need to take the drug.

Medicine _____ Dosage _____ Frequency _____

Medicine _____ Dosage _____ Frequency _____

Medicine _____ Dosage _____ Frequency _____

**In an emergency, if we are unable to contact parent or guardian, we should contact:
(Please list 2 [two] contacts.)**

Name _____

Name _____

Relationship _____

Relationship _____

Telephone Number _____

Telephone Number _____

Note to parent or guardian:

Permission for *Routine* and *Emergency* Medical Treatment

All attempts will be made to notify you if your child requires medical treatment. We do not wish to give any medical treatment to your child against your wishes or family practice. I hereby give permission for my child to receive routine 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 _____

Relationship _____ Date _____

Family Insurance Provider and Health Plan _____

Health Plan number (including expiration date) _____