

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

Participant's Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_

**HEALTH HISTORY**

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

**IMMUNIZATIONS** (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:** (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? \_\_\_\_\_ All medication is to be well labeled with clear, concise directions indicated here (frequently, dosage, etc.):

\_\_\_\_\_

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): \_\_\_\_\_

NOTARY INFORMATION BELOW  
NOT REQUIRED BY DIOCESE  
ONLY USE IF PARISH REQUIRES

Subscribed and sworn to before me on this \_\_\_\_ of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
(Signature)

Notary Public for \_\_\_\_\_ County,  
Michigan.

My commission expires on \_\_\_\_\_.

**DIOCESE OF LANSING**  
**THIS FORM IS EFFECTIVE July 1, 2008 - JUNE 30, 2009**