HEALTH HISTORY

(All information will be held in confidence except as necessary for protection of children)

Participant's Name _____

Sex _____ Birthdate _____-_____-_____ Age _____

Parent/ Guardian _____ Relationship to participant _____

Street Address _____ City _____ State _____ Zip Code _____

Home Telephone Number (___) _____ Work Telephone Number (__)_____

Cell # (____) _____ e-mail address _____

☐ My child has no physical, medical, or other condition that will affect or be affected by participation in Religious Education Activities. Further, my child has no allergy that should be disclosed to emergency medical personnel.

☐ My child *does have* a physical, medical, or other condition that will affect or be affected by participation in Religious Education Activities. *Or* my child has an allergy that should be disclosed to emergency medical personnel. (If you check this box, please provide a full explanation on the bottom of the reverse side of this sheet, and sign the reverse side. Your signature authorizes us, in good faith, to share the explanation with emergency medical personnel or other persons as we believe necessary to safeguard the well-being of your child.)

PERMISSION FOR DISCLOSURE AND EMERGENCY MEDICAL TREATMENT

The parish has my permission, in an emergency when parents or guardians cannot be contacted, to take my child to a hospital emergency room. The hospital and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child. I will be contacted as soon as possible and will be advised prior to any further treatment by the hospital or doctor. I understand and agree that I will be responsible for the emergency medical charges.

SIGNATURE_____DATE_____

FAMILY INSURANCE PROVIDER/HEALTH PLAN: _____

HEALTH PLAN NUMBER (Include expiration date): _____

In an emergency, when unable to reach parent/guardian contact:

Name _____Phone_____

Name _____Phone _____