

ST. ANDREW THE APOSTLE AND THE DIOCESE OF LANSING

HEALTH HISTORY AND MEDICAL RELEASE FORM

2017-2018 SCHOOL YEAR

Participants Name _____ Sex M F Birth Date _____

Parent/Guardian Name _____ Relationship to participant _____

Street Address _____ City _____ Zip _____

Home Telephone _____ Cell _____ Work _____

Student's Grade: _____ Grad. Yr. _____ Day Attending: _____ Time Attending: _____

HEALTH HISTORY

Family Doctor _____ Phone: _____

Family Dentist _____ Phone: _____

IMMUNIZATIONS up to date? **YES** **NO.** (if **NO**, 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

Information will be shared on a "need to know" basis with appropriate staff/volunteers only

CONDITION(S) (please check all that apply and describe them below)

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Severe Headaches |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Frequent Earaches | <input type="checkbox"/> Severe Homesickness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frequent Nosebleeds | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Other _____ |

DESCRIPTION:

MEDICATIONS: Is your child taking any medication? **YES** **NO.** If yes, list name of medication(s), frequency and dosage:

AIDE: Does your child require an aide **YES** **NO.** If yes, please explain:

Is the aide needed full time? _____ or part-time? _____ other? _____

LIMITATIONS: Does your child have any **PHYSICAL LIMITATIONS** ? ___YES ___NO. If yes, please explain:

Does your child have any **EMOTIONAL/PSYCHOLOGICAL LIMITATIONS** ? ___YES ___NO. If yes, please explain:

Does your child have a **LEARNING DISABILITY**? ___YES ___NO. If yes, please explain:

EMERGENCY INFORMATION

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

- 1) Name _____ Phone _____
- 2) Name _____ Phone _____

PERMISSION FOR MEDICAL TREATMENT

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

Family Insurance Provider _____

Health Plan Number _____ Expiration Date: _____

**** IMPORTANT ****

**If your child's medical condition changes,
it is your responsibility to contact the parish office
so that we can update medical information.**

This form is valid from July 1, 2017 through June 30, 2018