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)

- □ Allergies
- □ Asthma
- □ Blackouts
- □ Diabetes
- □ Dizziness
- □ Fainting Spells
- □ Frequent Colds
- □ Frequent Earaches
- □ Frequent Nosebleeds
- □ Kidney Problems
- □ Seizures
- □ Severe Headaches
- □ Severe Homesickness
- □ Other _____
- □ 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?_____

(over)

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:

Choose from list

_____

_____

_____

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

(over)