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)_____