## St. James Catholic Church

## MEDICAL HISTORY FORM- 2016/2017

Please read and complete ***both*** sides of this form for all minor children to provide clear instructions regarding permission for seeking medical treatment and releasing children to other adults in your absence.
**Medical information must be updated annually. Thank You.**

**Family Last Name: _____ Family Doctor: _____ Dr.'s Phone: _____**

**Family Address:_____City:_____Zip:_____**

Father's Name: _____ Mother's Name : _____

**Primary Phone Numbers**: Father_____ Mother_____

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**Child's Name:** _____Sex:_____Birthdate:_____Grade:_____

Please list your child's allergies, (include food & medicine), medical conditions, or medications:

_____

Please describe any learning challenges that we can help with:

_____

☐I certify that my child's immunizations are current. _____

**Child's Name:** _____Sex:_____Birthdate:_____Grade:_____

Please list your child's allergies, (include food & medicine), medical conditions, or medications:

_____

Please describe any learning challenges that we can help with:

_____

☐ I certify that my child's immunizations are current. _____

**Child's Name:** _____Sex:_____Birthdate:_____Grade:_____

Please list your child's allergies, (include food & medicine), medical conditions, or medications:

_____

Please describe any learning challenges that we can help with:

_____

☐ I certify that my child's immunizations are current. _____

**Permission for Routine Medical Treatment:**

All attempts will be made to notify you if your child requires medical treatment (i.e. cases of high, persistent fever; severe vomiting, etc.

We do not wish to give any medical treatment to your son/daughter against your wishes or family practice. Please read each of the following statements carefully and **sign only either A** or **B** which is in accord with your wishes:

**A** I grant permission for non-prescription medication (i.e., Tylenol, cough syrup, etc.) and routine non-surgical medical care to be given to my child, if deemed advisable by the designated supervisor(s).
Signature _____Date:_____

**B** I do not want **ANY** type of medication (except band-aides, ice packs) administered to my child, unless the situation is life threatening and emergency treatment is required.
Signature _____Date:_____

**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 understand that I will be contacted, as soon as possible, and will be advised prior to any further treatment by the hospital or doctor.

Signature_____Date_____

Print Parent Name_____

Family Insurance Provider/Health Plan_____

Health Plan Number _____

**In an EMERGENCY, and unable to reach parent/guardian, contact: (*Someone other than parents*):**

1._____Phone Number:_____

2._____Phone Number:_____

## Student Release Information

I authorize the following person(s) to pick up my child and/or children from their Religious Formation program/events if I am unable to pick up my child and/or children myself.

1) Name_____Relationship_____

Day Phone_____Evening Phone_____

2) Name_____Relationship_____

Day Phone_____Evening Phone_____

3) Name_____Relationship_____

Day Phone_____Evening Phone_____

**If someone is not allowed to pick up your child and/or children, please contact the Director of Faith Formation to provide information and instructions regarding the situation.**