ST. STEPHEN, MARTYR ROMAN CATHOLIC CHURCH
Youth Health Information

Attachments for Trips:

Copy of Insurance Card ☐

Current Photograph ☐

Height _________ Weight _________Eye Color ________ Hair Color ________

Personal Health and Medical History
(To be filled out by all participants)

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION

Name ____Date of Birth ________________Age _______Sex ________

Name of Parent or Guardian ____________________________________Phone # __________________________________

Home Address _______________________________________City ____________________State _______ZIP __________

Cell Phones: Mother _______________________Father _____________________Youth ____________________________

E-mail Addresses: Youth ________________________________Parent ____

If person(s) named above are not available in the event of an emergency, notify:

Name __________________________________Relationship __________________Phone # __________________________

Name __________________________________Relationship __________________Phone # __________________________

Name of Personal Physician ____Phone # ___________________________

Personal health/accident insurance carrier __________________________________Policy # __________________________

☐ Child does not have health insurance

(Please attach copy of current medical insurance card)

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes No Explain: ____

GENERAL INFORMATION:

	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit Hyperactivity Disorder)	☐	☐	Convulsions/Seizures	☐	☐	Hemophilia	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐
Cancer/Leukemia	☐	☐	Heart Trouble	☐	☐	Kidney Disease	☐	☐

Explain: ____

Please list ALL medications taken in the 30 days prior to departure for the location where this form is to be used:

____

List any medications to be taken on the trip:

Drug	**Dosage**	**Route** (Oral, Injection, Etc.)	**Frequency**

List any physical or behavioral conditions that may affect or limit full participation in strenuous activities:

____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc: ______________________________________

Immunizations: (Give date of last inoculation.)

Inoculation	Date	Inoculation	Date
Tetanus Toxoid		Measles	
OR DPT		OR MMR	
Hepatitis A		Varicella	
Hepatitis B		Polio	

I give permission for full participation in St, Stephen, Martyr Youth programs, subject to limitations noted therein.

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is adult).

Date ____________Signature of parent/guardian or adult ____