Our Lady of Mount Carmel Parish Religious Education Program
HEALTH AND MEDICAL RELEASE FORM FOR YOUTH 2018/2019

Name____ **Date of Birth**______________________
Address____ **Female**___________ **Male**__________
City_________________________________ **Zip**____________ **Phone** (___)______________________
Parish:____ **City**_______________________

Is this participant in general good health and able to participate in all activities involved in this event?

YES______ NO__________(If no, please submit a statement indicating limitations or serious medical conditions.)

Date: most recent physical exam: ___________ Physician or Clinic:________________________________

Address____________________________________ Phone: (_____)________________________________

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ALLERGIES (Please write yes or no next to each)
Hay Fever__________ Asthma__________ Poison Ivy__________ Sulfa__________ Nuts__________
Penicillin__________ Bee Sting__________ Other__________
Medicines____
If any of the above is yes, please submit a statement of how the child has been treated and with what medication. Any medication not able to be self-administered must be listed.

Operations or Serious
Injuries:____ Dates:____________________Please notify the event coordinator if this child is exposed to any communicable disease during the three weeks prior to activity.

Does the participant have any special dietary needs? If yes please list on reverse side of form.
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AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I/We, the undersigned, parent(s) of _______________________________________a minor, do hereby authorize as agent(s) ____ for the undersigned to consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act of the medical staff of any licensed hospital whether such diagnosis of treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our for said agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.
I agree that in the event my child is injured as a result of his/her participation in this event, including transportation to and from such activity through the negligence (active or passive) of the Our Lady of Mount Carmel Parish, or any of any of its agents or employees, recourse for the payment of any resulting hospital, medical or related costs and expenses will first be had against any accident, hospital, medical insurance, or any available benefit plan of mine or my spouse.

I also, give my child permission to self-medicate except for medications which are listed on the back of this form. I understand that any medications so listed will be dispensed by the Director of First Aid for the ____________________________________.
Event

This authorization shall remain effective from ____________________________ to ____________________________________

Event: ____

Signature of parent(s)/Guardian:____Date:__________________

Emergency Telephone Number: (_____)________________________ Cell Telephone: (_____) ____________________

Family Health Insurance Co:_______________________________________Policy No.__________________________________
(If possible please provide a copy of the insurance card)

Medication Name:
Dosage:
Frequency given:
Other Information:

Please list any special dietary needs: