HEALTH HISTORY AND MEDICAL RELEASE FORM
FOR ST. THOMAS AQUINAS PARISH SCHOOL PROGRAMS AND ACTIVITIES

Student's Name ________________________________Gender _______ Birthdate _________ Age

Parent/Guardian ____Relationship to student

Street Address _______________________City _________________, MI Zip Code ___________

Home Telephone ( ) ___________________ Work Telephone ( ) _______________________

Mother's Cell: ( ) _____________________ Father's Cell: ( ) ______________________

HEALTH HISTORY OF STUDENT

Family Doctor / Pediatrician _____________________________Telephone Number ( ) ___________________

IMMUNIZATIONS (Record YEAR of last immunization or last time person had disease):

Tetanus/Diphtheria ___________ Measles ___________ Mumps ___________

Chicken Pox ________________ Rubella ____________Polio ______________

TB __________(results) _______ Hepatitis B _________Other ___________

SPECIAL INFORMATION: (Please check all that apply. Information will be shared on a "need to know" basis or shared only with appropriate staff.)

Sleep Walking _____________Fainting ________________ Dizziness ________________

Blackouts _________________Asthma ___________________(Uses Inhaler ? ______________)

Kidney Problems ______________Frequent Earaches ___________

Frequent Nosebleeds ________Frequent Colds _____________Seizures _________________

Severe Headaches __________Severe Homesickness ________Diabetes _________________

ALLERGIC REACTIONS (Please list all known allergies - plant, insect, food, medicine AND TYPE OF REACTION):

____

Please indicate any other medical problems/situations pertinent to your child:

____

Any physical limitations? _____ If yes, explain ____

Any emotional/psychological limitations or reactions to be aware of? ______ If yes, explain: ___________________

____

Is the student presently taking any medication? ________ List all medications to be well labeled with clear, concise directions indicated here (frequently, dosage, etc.):

____

In an **EMERGENCY,** and if unable to reach parent/guardian, we should contact:

1. Name ________________________________Telephone Number ___________________________

2. Name ________________________________Telephone Number ___________________________

PLEASE FILL OUT BOTH SIDES

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 will be contacted as soon as possible and will be advised prior to any further treatment by the hospital or doctor.

*SIGNATURE ______________________________ DATE _________________________

FAMILY INSURANCE PROVIDER / HEALTH PLAN: ____________________________

HEALTH PLAN NUMBER (Include expiration date): _____________________________________

DIOCESE OF LANSING
This form is effective July 1, 2015 – June 30 2016