



**MEDICAL INFORMATION**

This form should be completed for any person (under 19 years of age) in parish religious education, Catholic schools, and youth programs and should be completed on an annual basis at the beginning of the program.

Diocese \_\_\_\_\_ Parish \_\_\_\_\_ School \_\_\_\_\_

Participant's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

PLEASE PRINT OR TYPE

**Participant's Regular Physician:**

Name (first, middle, last): \_\_\_\_\_ Phone (including area code): \_\_\_\_\_

**Medical Conditions:**

Please list any medical conditions of the participant (asthma, diabetes, epilepsy, etc): \_\_\_\_\_

List below any physical condition the sponsors, doctors, nurses, or other medical personnel should be aware of:

Insect stings: \_\_\_\_\_

Fainting spells: \_\_\_\_\_

Allergies: \_\_\_\_\_

Ear infections: \_\_\_\_\_

Seizures: \_\_\_\_\_

Heart condition: \_\_\_\_\_

Headaches: \_\_\_\_\_

OTHER: \_\_\_\_\_

List any allergies or allergic reactions to medications of the participant: \_\_\_\_\_

Other pertinent medical information: \_\_\_\_\_

Date of Participant's last immunizations: MMR \_\_\_\_\_ TB \_\_\_\_\_ TETANUS \_\_\_\_\_

Special dietary needs/restrictions: \_\_\_\_\_

**Medications:**

Prescribed medication now being taken:

Type: \_\_\_\_\_ Dosage: \_\_\_\_\_ How often: \_\_\_\_\_

Activities individual should not participate in: \_\_\_\_\_

**Medical Insurance Information:**

Company: \_\_\_\_\_

Plan Number: \_\_\_\_\_ Employee Identification #: \_\_\_\_\_

**Emergency Contacts:**

Parent or Guardian

Name (first, middle, last): \_\_\_\_\_

Daytime Phone (including area code): \_\_\_\_\_ Evening Phone (including area code): \_\_\_\_\_

Other Contact

Name (first, middle, last): \_\_\_\_\_ Phone (including area code): \_\_\_\_\_

Relationship (friend, neighbor, coworker, etc): \_\_\_\_\_