

# Foundations Leadership Health and Registration Form

Participants Name: \_\_\_\_\_

Parish: \_\_\_\_\_ Location: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Grade: \_\_\_\_\_ Gender: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**Parents Names :**

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Emergency Information: (if parents cannot be reached)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Health Insurance \_\_\_\_\_ Co.Policy # (last 4 digits) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Any allergies or special needs/concerns/dietary restrictions, health concerns:**

**Any medications (prescription and/or non-prescriptions) currently taking—include dosage:**

**Is there anything else we need to know about your teen?**

I give permission for the Diocese of Rochester to make use of pictures of my son/daughter for informational/advertising purposes only for Diocesan Programs  Yes  No

I hereby certify that the above information is correct and give permission for my child to be transported in privately owned vehicles for medical emergencies only, and for the release of medical records to an attending health care professional in case of illness. I understand that every effort will be made to contact the parent or guardian. If one cannot be contacted, I hereby give permission for a qualified physician to secure proper treatment for my child.

Parent/Guardian Signature \_\_\_\_\_

**Complete this form and return with payment (No Later Than February 11th) to:  
FOUNDATIONS Leadership ~ 1150 Buffalo Road ~ Rochester, NY 14624  
For information contact Mary Greenblatt at greenblatt@dor.org or call the Youth Ministry  
Office at 585-328-3228 x 1279 Outside Monroe County 1-800-388-3177 Fax 585-328-3149  
Check out our website at: www.dor.org**

Date: \_\_\_\_\_