

Diocese of Rochester Youth Health Form - Foundations 2013

Last Name: _____		First Name: _____	
Address: _____			
City: _____		State: _____	Zip: _____
Home Phone: (____) - _____		Cell Phone: (____) - _____	
E-Mail Address: _____		Grade _____	Sex: F ___ M ___
Parish Affiliation: _____		Location: _____	

<p>Mother's Information:</p> <p>Name: _____</p> <p>Work Phone: () - _____</p> <p>Cell Phone: () - _____</p> <p>E-Mail Address: _____</p> <p>Address if different from teen: _____</p>	<p>Father's Information:</p> <p>Name: _____</p> <p>Work Phone: () - _____</p> <p>Cell Phone: () - _____</p> <p>E-Mail Address: _____</p> <p>Address if different from teen: _____</p>
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Emergency Contact if Parent/Guardian is not available:	
Name: _____	Relationship: _____
Home Phone: (____) - _____	Cell Phone: (____) - _____

Health Insurance Co: _____	Policy Number: _____
Primary Care Physician: _____	Phone of Physician: _____

<p>List any allergies or special needs/concerns/dietary restrictions, health concerns:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>
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<p>List any medications (prescription and non-prescription) currently taking—include dosage:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>
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My child has can receive the following medications from the Program Coordinator if needed: (Please check the boxes below)		
Aspirin Yes <input type="checkbox"/> No <input type="checkbox"/>	Acetaminophen Yes <input type="checkbox"/> No <input type="checkbox"/>	Ibuprofen Yes <input type="checkbox"/> No <input type="checkbox"/>
I give permission for the Diocese of Rochester to make use of pictures of my child for informational/advertising purposes only for Diocesan programs. Yes <input type="checkbox"/> No <input type="checkbox"/>		

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/guardian. If one cannot be contacted, I hereby give permission for a qualified physician to secure proper treatment for my child.

Parent/Guardian Signature: _____ Date: _____

Adult Team Health Form

Last Name:	_____	First Name:	_____
Address:	_____		
City:	_____	State:	_____
		Zip:	_____
Home Phone:(____)-	_____	Cell Phone: (____)-	_____
E-Mail Address:	_____	Sex: F	_____ M
Parish Affiliation:	_____	Location:	_____

Emergency Contact:

Name:	_____	Relationship:	_____
Home Phone:(____)-	_____	Cell Phone: (____)-	_____

Health Insurance Co:	_____
Policy Number:	_____
Primary Care Physician:	_____
Phone of Physician:	_____

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

I hereby certify that the above information is correct and give permission for me 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.

Signature: _____ Date: _____