



ST. PETER  
CATHOLIC CHURCH

Health & Medical Release Form

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_  
Street Number & Name City, State Zip Code

Parent/Guardian \_\_\_\_\_ Phone (c) \_\_\_\_\_ (h) \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone (c) \_\_\_\_\_ (h) \_\_\_\_\_

**Emergency Contact (other than Parent/Guardian)**

1) \_\_\_\_\_ Phone (c) \_\_\_\_\_ (h) \_\_\_\_\_

Address \_\_\_\_\_  
Street Number & Name City, State Zip Code

2) \_\_\_\_\_ Phone (c) \_\_\_\_\_ (h) \_\_\_\_\_

Address \_\_\_\_\_  
Street Number & Name City, State Zip Code

**HEALTH HISTORY**

Any Pre-Existing or Present Medical Conditions:

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**Name and dosage of any medication that must be taken:**

(Medication must be clearly labeled and given to an adult chaperoning the event)

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**Allergies?**

Please check all that apply:

- Hay Fever    Asthma    Diabetes    Insect Stings    Epilepsy/Nervous disorder
- Frequent Stomach Upsets    Heart Condition    Physical Handicap    Recent Major Illness
- Other

If any of the above are checked, please provide details below:

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Date of last Tetanus shot \_\_\_\_\_

Contact Lenses? (Type) \_\_\_\_\_

Any swimming restrictions? \_\_\_\_\_

Activity Restrictions \_\_\_\_\_

Is the child under any special medical treatment or diet that needs to be observed?

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**INSURANCE INFORMATION:**

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

Insurance Policy #: \_\_\_\_\_

Insurance Certificate #: \_\_\_\_\_

If the situation permits, my first choice of hospital is: \_\_\_\_\_

Please understand that depending upon the seriousness of the situation; your child may be transported to the nearest hospital. I understand that I am responsible for the cost of any medical treatments received by my child. I hereby release the directors of St. Peter Church Youth Group from all responsibility for sickness or accidents which occur during the event. I understand that I will be contacted immediately in the case of an emergency.

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

\_\_\_\_\_  
Date