



SAINT NICHOLAS GREEK ORTHODOX CHURCH

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2008 – 2009 HEALTH and MEDICAL INFORMATION FORM

The parent/legal guardian of the child/children who are registered to attend these activities in order that the appropriate care is given if and when needed must complete this health form for your child/children to participate in this activity and MUST inform us of any changes through out the year immediately.

Childs Name: _____ Birth Date: _____

Address: _____ Gender: () Male () Female
Street City State ZIP

Name of custodial parent/legal guardian(s): _____
(Please Print)

Home Address: _____
(If different from above) Street Address City State ZIP

Father: Daytime Phone (____) ____ - ____ Evening Phone (____) ____ - ____ Cell Phone (____) ____ - ____

Mother: Daytime Phone (____) ____ - ____ Evening Phone (____) ____ - ____ Cell Phone (____) ____ - ____

If not available in an emergency, notify: Name: _____ Relationship: _____

Address: _____ Phone: (____) ____ - ____
Street City State ZIP

Insurance Information: Is the participant covered by family medical/hospital insurance? Yes () No ()

If so, indicate carrier or plan name: _____ Group # _____

Name and phone number of personal physician and practice: _____

I (we) give permission for above named minor to receive any emergency treatment (medical or surgical) and to receive basic medication or first aid from the adults on the trip. I (we) will assume responsibility for any such medical expenses incurred. The adults may administer: _____ Aspirin _____ Tylenol _____ Ibuprofen

Medication: **Please list and indicate any medications your child must take during the time of this treatment, if any.**

This minor takes no medications on a routine basis **or none that needs to be taken during the duration of the activity**

This person takes medications as follows (list names and dosages):

Medication #1: _____ Dosage _____ Specific times each day _____

Describe reaction (s) and management of the reaction and reason for taking:

Medication #2: _____ Dosage _____ Specific times each day _____

Describe reaction (s) and management of the reaction and reason for taking:

Medication Allergies

#1 _____

#2 _____

Food allergies (list all known)

My (our) child has been vaccinated for: _____ tetanus (give date of last booster) _____

List any dietary or physical restrictions, or other medical conditions (check where applicable) your child may have:

___ rheumatic fever ___ asthma ___ diabetes ___ motion sickness ___ heart problems ___ seizure disorder ___ urinary tract difficulties

___ difficulty getting along with peers or authority figures (explain): _____

___ other problems leading to unconsciousness (explain): _____

___ any recent medical care received? (explain): _____

Signed (Father): _____ Signed (Mother): _____