St. Francis de Sales CRE / Confirmation Program

818-784-0105

HEALTH AND MEDICAL RELEASE FORM FOR YOUTH

Name ______________________________ **Date of Birth** ____________

Address ______________________________ **Female** ________ **Male** ________

City ______________________ **Zip** ________ **Phone** (____) ____________

Is this participant in general good health and able to participate in all activities involved in this event?

YES______ NO________ - If NO, please list any limitations or serious medical conditions: ____________

____

Physician Name: ____________________ Phone: ( ) ________________

Address: ________________ City: ________________ Zip: ________

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ALLERGIES (Please write YES or NO next to each)

Hay Fever ________ Asthma ________ Poison Ivy ________ Sulfa ________ Nuts ________

Penicillin ________ Bee Sting ________ Other ______________________________

MEDICINES ____

If YES to any of the above, please indicate how the child has been treated and with what medication: ____________

____

Operations or Serious Injuries: ______________________________ Dates: ____________

Please notify the event coordinator if this child was exposed to any communicable disease during the three weeks prior to activity.

Does the participant have any special dietary needs? YES / NO -If YES, please list them below:

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<u>AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR</u>

I/We, the undersigned, parent(s) of ________________________ a minor, do hereby authorize as agent(s), Youth Ministry/St. Francis de Sales CRE/Confirmation Program, for the undersigned to consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act of the medical staff of any licensed hospital whether such diagnosis of treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our said agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

I agree that in the event my child is injured as a result of his/her participation in this event, including transportation to and from such activity through the negligence (active or passive) of St. Francis de Sales, or any of its agents or employees, recourse for the payment of any resulting hospital, medical or related costs and expenses will first be had against any accident, hospital, medical insurance, or any available benefit plan of mine or my spouse.

I understand that any medications necessary will be dispensed by the Director of First Aid.

This authorization shall remain effective from **September 2023-June 2024**

Signature of parent(s)/Guardian: ______________________________ Date: ____________

Emergency Telephone Number during Event (______) ____________ Alternate Telephone (______) ____________

Family Health Insurance Co: ______________________________

Please use reverse side of this form if any additional information is needed. Thank you.