

**Holy Family Parish  
High School Religious Education  
Overnight Retreat Medical Form**

Name of Participant: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

**EMERGENCY INFORMATION: Family Physician or Clinic:**

Name: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Policy Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**\*\*PLEASE ENCLOSE A COPY OF PARTICIPANT MEDICAL INSURANCE CARD\*\*  
(PLEASE INCLUDE A COPY OF A PHARMACY CARD, IF DIFFERENT)**

Is there anything about the participant's health that we should be aware of such as:

_____ Diabetes	_____ Fainting Trouble	_____ Seizure Activity
_____ Heart Problems	_____ Migraines	_____ Bleeding Disorders
_____ Asthma	_____ Severe Allergic Reactions (Bee Sting/Food/other)	
_____ Other health issues we should be made aware of _____		

If any of the above is checked, please indicate (submit a statement if long) how the participant has been treated and with what medication(s) – (epi pen, inhaler, insulin shots, pills, etc.)

\_\_\_\_\_  
\_\_\_\_\_

The participant **is or may be** allergic to (food, insect bites, medications, pollen, nuts, etc.):

\_\_\_\_\_

The participant must take the following medications: (please indicate dosage, frequency, reason for medication etc.): \_\_\_\_\_

\_\_\_\_\_

**\*PLEASE BE ADVISED THAT WE CANNOT DISPENSE MEDICATION\***

**Immunization History: Please give dates of last shots:**

Tetanus: \_\_\_\_\_

MMR: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian/Participant 18 years old or older

\_\_\_\_\_  
Date