

**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