ST. JOSEPH'S YOUTH MINISTRY
Youth Health History Form

OUR DIOCESE REQUIRES THAT THE HEALTH HISTORY OF EACH YOUTH BE UPDATED YEARLY, IN ORDER FOR YOUTH TO PARTICIPATE IN CHURCH EVENTS! *It is the responsibility of the parent/guardian to inform the church of any changes in health status for the named participant. Please complete this form and mail it to the church or drop it in the collection basket during Mass…thanks for taking the time to fill this out!*

Youth Name ____ **Date of Birth** _____/_____/_____
Age _____ **Grade:** ______ **Gender: M / F**
Address____
City_______________________________________ **State**________ **Zip Code**_____________
Phone #(______)_______________ **Email** ____

Last Tetanus ____/____/____ **Are immunizations up to date?** Yes / No

ILLNESSES & INJURIES (Put an 'X' by all that participant currently has or has had in the past.)

( ) Anorexia
( ) Asthma
( ) Bleeding/Clotting Disorder
( ) Bulimia
( ) Chicken Pox
( ) Chronic Ear Infection
( ) Diabetes
( ) Epilepsy
( ) Hay Fever
( ) Heart Disease
( ) Hypertension
( ) Kidney Disease
( ) Measles
( ) Migraines
( ) Mumps
( ) Rheumatic Fever
( ) Scarlet Fever
( ) Seizures
( ) Scoliosis
( ) Sinus Trouble
( ) Other – ____

ALLERGIES: (Specify)
Animals ___________________________________ Medicine/Drugs _________________________________
Food _____________________________________ Hay Fever/Pollen/Plants__________________________
Insect Stings ______________________________ Other ____

ARE YOU TAKING PRESCRIPTION OR OVER THE COUNTER MEDICATION ROUTINELY? YES NO
Medicine ____________________ **Reason** __________________ **Dosage** ____________
Medicine ____________________ **Reason** __________________ **Dosage** ____________
Medicine ____________________ **Reason** __________________ **Dosage** ____________

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your youth is participating in the activity. **Do you have health insurance?** _______

Name of Primary Insured ____
Relationship to Participant____
Insurance Carrier_____________________________________ Policy or Group # ___________________________
Family Physician____
Physician Phone Number: Daytime (____)_________________ Evening (____)__________________

IN CASE OF MEDICAL EMERGENCY, *I understand that when medically feasible, every effort will be made to reach the parent/guardian listed on this form, but in the event one cannot be reached or if it is not medically feasible to contact one, I hereby give permission to the physician or dentist selected by the adult leaders to hospitalize, to secure medical treatment and/or to order an injection, anesthesia, or surgery for my child as deemed necessary for treatment. I understand that all reasonable safety precautions will be taken at all times by* **St. Joseph Church** *and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold* **St. Joseph Church**, *its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.*

Signature of Youth if over 18 years of age: ______________________________________ **Date** __________________
Parent/Guardian Signature____ **Date** __________________
Print name of Parent/Guardian ____ **Date** __________________
Phone number: Home (_____)_____________ Work (_____)______________ Cell (_____)__________________
Emergency Contact: _________________________________ **Phone # (_____)**_____________ **Relationship:** ___________
HOSPITAL PREFERRED:____