St. Angela Merici Catholic Church ~ YOSA ~

Medical Questionnaire and Emergency Medical Authorization

Student Information… ***Please PRINT legibly.***

Last Name: ______________________________ Date: ____________________

First Name: ______________________________ School: ____________________

Address:______________________________ Grade: ____________________

City: ____________ Zip:________________ Date of Birth: ______________

Home Phone: ____________ Cell Phone: ____________ Adult T-Shirt Size: __________

STUDENT LIVES WITH: ☐ Mother & Father ☐ Mother & Stepfather ☐ Father & Stepmother ☐ Father Only ☐ Mother Only ☐ Guardians

Mother's Full Name: ____________________ Cell Phone: ____________________

Mother's Occupation: ________________ Work Phone: ____________________

Father's Full Name: ____________________ Cell Phone: ____________________

Father's Occupation: ________________ Work Phone: ____________________

Additional Emerg. Contact: ________________ BEST Phone Number: ________________

Address: ________________________ Relation to student: ________________

STUDENT MEDICAL HISTORY

Has this student been diagnosed with any of the following conditions? If so, please check whether the condition is current or past history and if medication is currently being taken.

Condition	Current	Past History	Takes Medication	Notes
Allergies	_____	_____	_____	
Asthma	_____	_____	_____	
Bee stings	_____	_____	_____	
Diabetes	_____	_____	_____	
Heart Condition	_____	_____	_____	
Migraines	_____	_____	_____	
Seizures	_____	_____	_____	
Ulcers	_____	_____	_____	

Please explain any condition checked above…

____

____

Any condition not listed above (list and explain)…

____

____

Food / Dietary Allergies or special needs (list and explain)…

____

____

____

MEDICATIONS

List medications this student is presently taking, dosage, frequency, and medical condition.

Medication________________Dosage_______________Frequency_________________Condition__________________

Medication________________Dosage_______________Frequency_________________Condition__________________

Medication________________Dosage_______________Frequency_________________Condition__________________

I give permission for the youth ministry staff/volunteers to administer the following otc medications in proper dosages…

☐ Acetaminophen-Tylenol ☐ Ibuprofen-Advil ☐ Benadryl

Please list and explain any past or present serious illness or hospitalization that we should be aware of.

____

____

Please explain any additional health problems, limitations, or special conditions that we should be aware of for emergency treatment of this student.

____

____

***Purpose** – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.*

PART I OR II MUST BE COMPLETED
PART I TO GRANT CONSENT

In the event reasonable attempts to contact ME at ______________________________ (phone number) OR _______________________ (alternate phone number) OR _______________________ (other parent or guardian) at _______________________ (phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr._____________________________ (preferred physician) or Dr.__________________________________(preferred dentist), or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _______________________________ (preferred hospital) or any hospital reasonably accessible.

Health Insurance Carrier: ____

Policy #: ____

Name of Policy Holder:____

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

____

____

____

_____________________________ ____

Date **Signature of Parent or Guardian**

***DO NOT* COMPLETE PART II IF YOU COMPLETED PART I**
PART II REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

____

____

_____________________________ ____

Date **Signature of Parent or Guardian**