St. Elizabeth of Hungary High School Youth Ministry
Serving Youth in Acton, Boxborough and Beyond

Name of Event ____________________
Date of Event __________________

Medical Information

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: ________________________

*********<u>MUST</u> ENCLOSE A COPY OF MEDICAL CARD*********

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 submit a statement of how the person 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