Saint Elizabeth Roman Catholic Church -Youth Ministry
2010-2011 Medical Emergency Information

Child's Name: _____ _____
(Last) (First)
Address: _____

Telephone:_____ E-mail: _____

DOB: _____ Grade (10-11)_____

Father's Name: _____

e-mail:_____

Phone - Home: _____Cell: _____Work:_____

Mother's Name: _____e-mail_____

Phone - Home: _____Cell: _____Work:_____

Family Doctor: _____Phone:_____

Family Medical Coverage:_____

Plan/Group ID Numbers: _____

Subscribers Name_____ Subscribers DOB_____

Medical History
Does child wear contact lenses? Yes _____ No_____
Does child have heart condition? Yes _____ No_____
Does child have any ear or nose conditions? Yes _____ No_____
Does child have diabetes? Yes _____ No_____
Does child have asthma? Yes _____ No_____
Does child have epilepsy? Yes _____ No_____
List all allergies _____
List medications child is currently taking _____
Date of last Tetanus Toxoid Injection _____
List any other health concerns _____
My child has permission to be given Tylenol or Ibuprofen if they request _____ (Yes/No)

In the event of an emergency, I hereby give permission to the St. Elizabeth's Youth Ministry and staff to secure proper emergency treatment from a licensed physician or to facilitate transportation of my child to the nearest hospital for emergency treatment, or to _____Hospital.

SIGNATURE_____DATE_____