

SAINT ELIZABETH ROMAN CATHOLIC CHURCH
PO Box 780, Uwchlan, PA 19480
YOUTH MINISTRY

2008-2009 Medical Emergency Information

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

Address: _____

Telephone: _____ E-mail: _____

DOB: _____ Grade (08-09) _____

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 Athletic Ministry and its 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 _____