



St. Bernardine of Siena Youth Ministry

24410 Calvert Street, Woodland Hills, CA 91367

www.stbernardine.org/youth.htm

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Adult Health and Medical Form

Name _____

Date of Birth ____/____/____

Address _____

Gender: M F (circle)

City _____ State _____ Zip _____

Phone Number _____

Date of most recent physical exam: ____/____/____ Physician or Clinic: _____

Address: _____ Phone Number: _____

Are you in general good health and able to participate in all activities?

(circle one) YES NO (If no, please attach a statement indicating limitations.)

Medical Insurance Carrier: _____ Name of Policy Holder: _____

Policy/Member #: _____ Benefit/Plan/Group/ID #: _____

(Please attach a copy of your insurance card to this form in case of emergency.)

In order for us to provide a safe and healthy experience for you, please list all medical/mental health needs that you are currently being treated for:

Please list any allergies that you have (medical, food, environmental, etc.) and indicate treatment (if any):

Allergy

Reaction

Treatment

Do you tend to suffer from motion sickness? YES NO

(If YES, please take proper precautions before events/outings that might lead to motion sickness for you.)

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Please list any prescription and over the counter medications that you are currently taking:

Medication Name	Dosage	Times administered	Other Information
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Do you have any special dietary needs, please specify:
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Authorization to Consent to Treatment

I, the undersigned, warrant and represent that I am eighteen years of age, or over, and upon request will produce satisfactory proof of such fact. I hereby authorize St. Bernardine of Siena Church / Archdiocese of Los Angeles staff/volunteers, as agents for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act of the medical staff of any licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

I agree that in the event that I am injured as a result of my participation in events, including transportation to and from activities, through the negligence (active or passive) of the Archdiocese of Los Angeles, or any of any of its staff/volunteers or agents, recourse for the payment of any resulting hospital, medical, or related costs and expenses will first be had against any accident, hospital, medical insurance, or any available benefit plan of mine or my spouse.

(Authorization given pursuant of the provisions of section 25.8 of the civil code of California.)

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Signed, _____ Please print name here: _____

Home Phone _____, Work Phone _____, Mobile Phone _____

Authorization signed on _____, 20____ to remain effective for twelve months from this date.

Emergency Contact _____ Relationship _____

Home Phone _____, Work Phone _____, Mobile Phone _____