



St. Bernardine of Siena Youth Ministry

24410 Calvert Street, Woodland Hills, CA 91367

www.stbernardine.org/youth.htm

Andrew Gafvert, Program Coordinator

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Youth Health and Medical Form

Youth's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Gender: M F (circle)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_ please circle one: Father Mother Step Parent Guardian

Name of Parent/Guardian \_\_\_\_\_ please circle one: Father Mother Step Parent Guardian

Date of most recent physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Physician or Clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Is the participant 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 insurance card to this form in case of emergency.)

In order for us to provide a safe and healthy experience for your son/daughter, please list all medical/mental health needs that your child is currently being treated for:

Please list any allergies that your child has (medical, food, environmental, etc.) and indicate treatment (if any):

Allergy Reaction Treatment

Does your child tend to suffer from motion sickness? YES NO (If YES, please take proper precautions before events/outings that might lead to motion sickness for your youth.)

I \_\_\_\_\_ (parent's name), give my permission to the staff/volunteers of St. Bernardine Parish to dispense the following (as specified below) over the counter medications as needed (per the recommended dosage) to my son/daughter \_\_\_\_\_ (child's name).

PLEASE CIRCLE YES IF YOU GIVE PERMISSION, NO IF YOU DO NOT, FOR EACH:

Acetaminophen YES NO Ibuprofen YES NO Diphenhydramine HCL (Antihistamine) YES NO Pepto Bismol YES NO Tums YES NO Dimenhydrinate/Meclizine HCL (Motion Sickness) YES NO Pseudoephedrine/Phenylephrine HCL (Nasal Decongestant) YES NO Excedrin YES NO Cough Drops YES NO

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Please list any medications that your son/daughter is currently taking  
**THAT YOU GIVE YOUR CHILD PERMISSION TO POSSESS AND SELF-ADMINISTER:**

Medication Name                      Dosage                      Times to be administered                      Other Information

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Please list any medications that your son/daughter is currently taking  
**THAT YOU WILL PROVIDE TO PARISH STAFF/VOLUNTEERS TO DISPENSE TO YOUR CHILD**  
(APPLICABLE ONLY IN THE CASE OF ALL DAY OR OVERNIGHT EVENTS/OUTINGS OR BY REQUEST):

Medication Name                      Dosage                      Times to be administered                      Other Information

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Does your child have any special dietary needs, please specify:

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**Authorization to Consent to Treatment of Minor**

I/We, the undersigned, parent(s) of \_\_\_\_\_, a minor, do hereby authorize as agent(s) St. Bernardine Parish Staff/Volunteers 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 the authority and power on the part of our for said 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/We agree that in the event my/our child is injured as a result of his/her 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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Signature of Parent/Guardian \_\_\_\_\_ please circle one:    Father    Mother    Guardian

Home Phone \_\_\_\_\_, Work Phone \_\_\_\_\_, Mobile Phone \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ please circle one:    Father    Mother    Guardian

Home Phone \_\_\_\_\_, Work Phone \_\_\_\_\_, Mobile Phone \_\_\_\_\_

Authorization signed on \_\_\_\_\_, 20\_\_\_\_ to remain effective for twelve months from this date.

Please provide an additional Emergency Contact (**other than either parent/guardian listed above**)

Name \_\_\_\_\_ Relationship to Minor \_\_\_\_\_

Home Phone \_\_\_\_\_, Work Phone \_\_\_\_\_, Mobile Phone \_\_\_\_\_