# St. Bernardine of Siena Youth Ministry

**24410 Calvert Street, Woodland Hills, CA 91367**
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## Youth Health and Medical Release Form

Youth's Name ______________________________ Date of Birth _____/_____/______

Address______________________________ Gender: __ M ___F

City ______________________ State_____ Zip _________ Home Phone _______________

Name of Parent/Guardian ______________________ please circle one: Father Mother Stepparent Guardian

Name of Parent/Guardian ______________________ please circle one: Father Mother Stepparent Guardian

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Youth's Physician or Medical Clinic: ____________________ Phone Number: ____________________

Address:______________________________

Is the participant in general good health and able to participate in all activities? **(Check one)** ___ YES ___NO

**(If no, please attach a statement indicating limitations or conditions.)**

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Medical Insurance Carrier:____________________ Name of Policy Holder: ____________________

Identification Numbers (ID#, Record#, Member#, Group#, etc.) ______________________________

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For us to provide a safe and healthy experience for your son/daughter, please list all medical/mental health needs or conditions that your child has been or is being treated for (attach additional pages as necessary):

______________________________

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

Allergy Reaction Treatment (if any)

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Does your child tend to suffer from motion sickness? YES NO Sometimes

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

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**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 CHECK YES IF YOU GIVE PERMISSION, NO IF YOU DO NOT, FOR EACH:**

Acetaminophen: ___YES ___NO Diphenhydramine HCL (Antihistamine): ___YES ___NO Excedrin: ___YES ___NO

Ibuprofen: ___YES ___NO Dimenhydrinate or Meclizine HCL (Motion Sickness): ___YES ___NO Tums: ___ YES ___NO

Pseudoephedrine HCL or Phenylephrine HCL (Nasal Decongestant): ___YES ___NO Antibiotic Ointment: ___YES ___NO

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 OR 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 of 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 St. Bernardine of Siena Parish, or any of its agents or employees, 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.

Name of Parent/Guardian ______________________________ Signature ______________________________

Home Phone________________, Mobile Phone______________________________

Name of Parent/Guardian ______________________________ Signature ______________________________

Home Phone______________________________ Mobile Phone______________________________

Authorization completed on ___/___/___ and to remain effective for twelve months from this date.

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

Name ______________________________________ Relationship to Minor ______________________

Home Phone: ______________________________ Mobile Phone: ______________________________