

2008-2009

Teen Information – MUST BE COMPLETED ONCE EACH YEAR!

(This information will not be handled by anyone except the youth director unless it is an emergency requiring medical attention.)

Teen full name: _____

Address: _____

City: _____ State: _____ Zip: _____

Teen's home number: _____ Cell number: _____

Father's full name: _____

Work number: _____ Cell number: _____

Mother's full name: _____

Work number: _____ Cell number: _____

Teen's medical insurance

Name of provider: _____

Policy number: _____

Group number: _____

Give the name, address and phone number of someone to contact in case a parent is unavailable in an emergency.

Name: _____

Relationship to teen: _____

Address: _____

Phone Number: _____

Other Medical Treatment: In the event it comes to the attention of the parish/school/institution, its officers, directors and agents, and the Archdiocese of Mobile, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

Signature: _____ Date: _____

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

Signature: _____ Date: _____

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature: _____ Date: _____

I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

OVER

Specific Medical Information: The parish will take reasonable care to see that the following information will be held in confidence:

Allergic reactions (medications, foods, plants, insects, etc.): _____

Immunizations: Date of last tetanus/diphtheria immunization: _____

Does child have a medically prescribed diet? _____

If yes, what is it? _____

Does child have any physical or other limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bed-wetting, fainting? _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox,

flu, etc.? _____ If yes, list date and disease or condition: _____

You should be aware of these special medical conditions of my child:

