



HEALTH INFORMATION/RELEASE FORM
(PRINT CLEARLY, FILL OUT COMPLETELY)



The information requested will be used to provide proper medical treatment to the YTM participant in case the need arises.

Name (Last) (First) (MI)

Age Date of Birth Sex

Insurance Name

Subscriber/Resp. Party Name

Subscriber ID# Group #

Emergency Contact

Phone#() Relationship to Patient

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE- I authorize the release of any medical/pharmacy information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. This signature gives authorization for one year from the date listed below.

Signed Date

I authorize payment of medical/pharmacy benefit to Saint John's Health Center for service and supplies described. This signature gives authorization for one year from the date listed below.

Signed Date

In the event that my insurance does not cover treatment at this clinic I agree that I am responsible for payment.

Signed Date

The health history listed on back is correct as far as I know, and the above named participant has my permission to engage in all program activities at this event except as noted. I understand that an EMT or First Responder will be continually available at St. John's University and that adult supervision will be provided. If a serious illness or injury develops, medical and/or hospital care will be given. Staff members for the activity are not responsible in case of accidental injury or illness. I further understand that in case of medical emergency I will be notified. In the event I cannot be reached I hereby give my permission to the attending physician to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for the child as named above.

Signature of Parent or Guardian Date

(OVER)

HEALTH HISTORY

Participant has or is subject to: (check if yes)

Asthma Convulsions Fainting spells
 Bronchitis Diabetes Heart trouble
 Other _____

Allergies or reactions to: (check those appropriate)

Drugs: Penicillin Aspirin Other: _____
 Tetanus antitoxin
 Tetanus toxoid
Date of last Tetanus shots: _____

Foods: _____
 Hay Fever
 Insect Bites or Stings
 Ivy, oak, and/or sumac poisoning

Participant has difficulty with: (check if yes)

Eyes, ears, nose, throat Digestion Menstrual problems
 Lungs Bed Wetting Sleep walking
 Other: _____

Participant has a current condition requiring medication? Yes No

If yes, please indicate condition _____

Is medication in possession of participant? Yes No

Who should administer medication? Participant Program Staff

Name of medication _____

List any specific activities to be restricted: _____

When water sports are part of free time activities, my son/daughter may participate in:

Swimming Yes No

Canoeing or boating Yes No

Please indicate any other health information you would like to share:
