

OLGC Workcamp 2007 - Health Information Form

NAME: _____

DOB: _____ SSN: _____

Address: _____

Phone (h): (____) _____

City: _____

State: _____ Zip: _____

Father's Name: _____

Work Phone: (____) _____

Father's email: _____

Cell Phone: (____) _____

Mother's Name: _____

Work Phone: (____) _____

Mother's email: _____

Cell Phone: (____) _____

Name of Person(s) having legal custody:

Child's Doctor: _____

Phone: (____) _____

Known Allergies: Food:

Medicine: _____

Medications being taken:

Are your immunizations up to date? _____ Date of Last Tetanus:

Insurance company: _____ Policy #:

Policy holder's Name: _____ DOB: _____ SSN:

Relationship: _____ Insurance State or Federal:

Emergency Contacts: In the event a parent cannot be reached, give the name, address and phone number of two persons who to reach in a timely manner.

1) Name: _____

Phone(s): _____

Address: _____

Relationship: _____

2) Name: _____

Phone(s): _____

Address: _____

Relationship: _____

I hereby authorize OLGC Adult leaders to dispense the following over the counter medicines
to my child:

_____ Tylenol _____ Ibuprofen _____ Benadryl _____ Aspirin _____
Neosporin

I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expense involved. I agree to indemnify the Parish, Youth Ministers, Volunteers, and the Diocese of Arlington for any costs or expenses arising out of my child's participation in the activities.

Parent's Signature

Date

Parent's Signature

Date