DIOCESE OF OAKLAND
Office of Youth Ministry
PARENTAL PERMISSION, HEALTH AUTHORIZATION, RELEASE FORM
THERE MUST BE A COPY OF THIS FORM AT ALL YOUTH MINISTRY ACTIVITIES
CHURCH OF ST. JOHN THE BAPTIST

Child's Name:____ Date: _______________

Address:____________________________________ Home Phone:________________________

School:_____________________________________ Grade:________ Birth Date:____________

Parent/Guardian Name:____________________________________ Work#:______________________

Address if different from above:_____________________________ Cell#:________________________

IN CASE OF EMERGENCY, NOTIFY PERSON OTHER THAN PARENT/GUARDIAN

Name:____ Phone:______________________

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HEALTH AND MEDICAL INFORMATION

Family Physician: ___________________________________ Address:____________________________

Phone:____ Medical Plan:________________________

Plan #:_____________________________

Do you authorize the adult leader to authorize medical treatment for your child in an emergency, as considered necessary by the attending physician? [ ] Yes OR [ ] No.

State any reasons why you do not want medical care given to your child in an emergency:

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Has your child had difficulty with the following (circle all that apply): Menstrual Digestion
Asthma Fainting Spells Convulsions Diabetes Heart
Eyes Nose Ears Throat Lungs
Other:____

List any physical restriction or restrictions for any activity on the basis of medical condition:

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State the date of your child's last physical examination:____________________________________
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