Our Mother of Good Counsel Youth Ministry
2060 North Vermont Avenue, Los Angeles, CA 90027
Tel: (323) 664-2111 Fax: (323) 664-0556

HEALTH AND MEDICAL RELEASE FORM

Minor's Name____Phone:_________________________________
Address____City_______________________________Zip_____________
Date of Birth_______________________________Gender (M/F):___________

Is this participant in general good health and abe to participate in all activities involved in this event?
YES_________ NO__________ (If no, please submit a statement indicating limitations.)

Date of most recent physical exam:______________Physician or Clinic____
Address____Phone: ________________________________

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IMMUNIZATION HISTORY (Please give dates)
DPT________________ DPT BOOSTER__________________ TETANUS BOOSER__________________
POLIO SERIES______________________POLIO BOOSTER____________________

ALLERGIES (Please write yes or no next to each)
Hay Fever______Asthma________Convulsions_______Penicillin_______Bee Sting______Other___________________________

If any of the above are yes, please submit a statement of how the child has been treated and with what medication. Any medication not able to be self-administered must be listed on the back form.

Operations or Serious Injuries:____Dates:______________
Please notify the Program Director if this child is exposed to ay communicable disease during the three weeks prior to the event.

Does the participant have any special dietary needs? If yes, please list on reverse side of form.
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I/We, the undersigned, parent(s) of ____, A Minor, do hereby authorize Our Mother of Counsel Parish and all officers, agents, employees, and volunteers as agent(s) 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 it is given to provide authority and power on the part of our for said agent(s) to give specific consent to an and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

I agree that in the event my child is injured as a result of his/her participation in this event, including transportation to and from such activity through the negligence (active or passive) of the Archdiocese of Los Angeles, or any of 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.

I also give my child permission to self-medicate except for medications which are listed on the back of this form. I understand that any medications so listed will be dispensed by the Director of this event.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain effective from August 11th, 2005 to ____________________________________(18th birthdate).

Signature of Parent(s)/Guardian____Date____________________

Telephone during event____________________________Alternate Tel.No.______________________________________

Family Health Insurance Co:_______________________________**Policy No.**_____________________________________