

**St. Patrick Cathedral
Office of Faith Formation
HEALTH INFORMATION FORM**

Today's Date: _____

Child's Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Parents: _____ Cell Phone: _____

Emergency Contact: _____ Telephone: _____

Physician: _____ Telephone: _____

Medical Insurance: _____ Policy # _____
Insurance Company Name

MEDICAL CONDITIONS (check those that apply)

___ ADD ___ ADHD ___ Asthma ___ Convulsions/Seizures

___ Diabetes ___ Dietary concerns ___ Epilepsy ___ Hearing difficulties

___ Heart disease ___ Learning challenges (ie. dyslexia) ___ Vision difficulties

Medications taken on a regular basis: _____

ALLERGIES (check those that apply)

___ Animals ___ Food ___ Medicine ___ Bee stings ___ Other

Please explain: _____

Does your child carry an EpiPen? ___ Yes ___ No

Does your child know how to use it? ___ Yes ___ No

PERMISSION TO SEEK MEDICAL HELP

If I cannot be reached in the case of emergency, the bearer of this form is authorized to act on my behalf to seek medical treatment as they deem necessary for my child.

Parent/Guardian Signature

