HOLY TRINITY REGISTRATION AND MEDICAL HISTORY FORM AND

(Please Print Clearly)

____GOYAN ____Advisor ____Coach ____Priest ____Driver

Participant's Name (last, first):____
Participant's Cell _____________________ Participant's Email_____________________
Date of Birth: ________________________Age:_________Grade (Fall 2010):________
Address____
City: _______________________________ State:__________ Zip: _________________
Parish Name/City/State: ____
Mother's Name______________________________________Cell #:________________
Mother Email____
Father's Name_______________________________________Cell #:________________
Father's email____
Physician's Name___________________________________ Phone: ______________
Physician's address: ____
Hospital of Choice: _______________________________________Tel#:____________
Dentist's Name____ Tel#:______________
Dentist's Address: ____

CHRONIC CONCERNS: Check all that pertain to your child and provide information about supportive health care.

_______I have no chronic health concerns.
_______I have the following chronic health concern (s):
___Asthma ___ Headaches/Migraines ___Sleep problem ___Diabetes ___Difficult breathing ___Dysmenorrhea ___Fainting ___Seizure disorder ___Back pain or injury ___Knee or ankle weakness
Other ____

GENERAL PHYSICAL HISTORY

1. Do you have skin problems (itching, rashes, acne)? ___Yes ___No
2. Has your child ever had a seizure? ___Yes ___ No
3. Has your child ever had a stinger, burner, or pinched nerve? ___Yes ___ No
4. Has your child ever had heat or muscle cramps? ___Yes ___No
5. Has your child ever been dizzy or passed out in the heat? ___Yes ___No
6. Has your child ever sprained, strained, dislocated, fractured, broken, or had repeated swelling or other injuries to any of your body areas? ___Yes ___No
If so, where? ____Head ____Shoulder ____Thigh ____Neck ____Chest ____Forearm ___Shin/calf ____Back ____ Wrist ____Hand ____Ankle ____Elbow ____Knee ____Hip ____Foot
7. Has your child had mononucleosis in the past nine months? ____Yes ____No
8. Does your child have any problems with their teeth? ____Yes____ No
9. Has your child ever been hospitalized? ____Yes ____No
10. Has your child ever had surgery? ____Yes ____No

If yes on any question please explain:____
____
____

Known Allergies (food, seasonal, etc):____
____

Type of reaction (be specific):____
____

Medicine for Allergies, dosage and how to administer:______________________________
____

Does your child have any drug allergies? ____Yes ____No
If yes, Name of Drug(s):____
Activities your child CANNOT participate in: ____
Special dietary needs (e.g vegetarian, vegan, dairy)_________________________________
Has your child had a Tetanus Shot within the past 5 years? ____Yes ____ No
Is your child taking either prescription or over-the counter medication on a regular basis? ____Yes ____No
Name of drug/ dose/ time of day it is taken______________________________________
____

Physician prescribing drug: ____

List names and telephone numbers of two persons to contact if your child is ill or injured. In the event that the parent or guardian cannot be contacted, these persons may have to make a medical decision.

1. **Name**__________________________________**Relationship**______________
   Home phone ______________________ **Cell Phone**_______________________
   Work Phone_________________________
2. **Name**__________________________________**Relationship**______________
   Home Phone______________________ **Cell Phone**_______________________
   Work Phone _________________________

We are extremely concerned about your child's spiritual well being and will minister to them as best we can, we are not equipped to handle serious mental illness and emotional disorders. By signing and submitting this health form, you are guaranteeing that, to the best of your knowledge, your child has no known serious mental illness or emotional disorders. If you have any questions or concerns in this matter, please feel free to contact Fr. Grigorios Tatsis at 404.634.9345 extension 25.

EMERGENCY MEDICAL TREATMENT

In the event that I am unable to be reached and my child needs EMERGENCY MEDICAL TREATMENT during any time he/she participates in Camp, you have my permission, and I hereby designate you my agent, to act in my son's/daughter's best interest in obtaining necessary transportation and medical care until I can be contacted. I hereby release you from any claim arising out of your and the doctor's actions relating to my child's illness/injury, and I assume and agree to pay for any professional medical services and other fees/costs incurred.

Parent/Guardian Printed Name
(Please print clearly)____

Parent/Guardian Signature:_________________________________ **Date**___________