

Saint Helen's Catholic Church  
**EDGE – WINTER DAY RETREAT**  
**Health and Medical Record-Permission Slip**  
**FEBRUARY 25, 2012**

Cost \$25.00

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Please Attach Photocopy Of Insurance Card. If Family Has No Medical Insurance, State "None"**

Family Medical Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

**In Case of Emergency, Notify:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_  
Alternate Contact: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

**Participant Health History**

Are you now, or have you ever been treated for any of the following: (Answer "Yes" or "No")

Sinus Trouble	_____	Kidney Disease	_____	Earaches/infections	_____	Hay Fever	_____
Asthma	_____	Fainting Spells	_____	Abdominal Problems	_____	Epilepsy	_____
Heart Trouble	_____	Tuberculosis	_____	Frequent Diarrhea	_____	Diabetes	_____
Mental Illness	_____	Rheumatic Fever	_____	Menstrual Problems	_____		

Allergies or reactions to any medication? Yes / No Define \_\_\_\_\_

Allergy to bee, wasp or hornet stings? Yes / No Which? \_\_\_\_\_

Operations, serious injuries or hospitalization with date(s), for any reason \_\_\_\_\_

Any restriction of activity for medical reasons? Yes / No Explain \_\_\_\_\_

**Medication Information**

Medication(s) / Strength / Dose: \_\_\_\_\_

Reason for medication(s) \_\_\_\_\_

When should medication be dispensed? \_\_\_\_\_

My son / daughter has my permission to carry and administer the above medication(s). Yes / No

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**PARENT'S / GUARDIAN'S AUTHORIZATION – REQUIRED FOR THOSE UNDER 18 YEARS OF AGE**

I, the undersigned, have read and understand this form. This health history is accurate and complete and the person herein described has permission to engage in all activities, except as specifically notes on this form. If I cannot be reached in an emergency, I hereby give permission for medical personnel, or the adult advisors in charge, to treat, hospitalize, secure anesthesia or to order injection, surgery or other treatment for the person described herein.

**Other comments regarding the health history of the participant that could be useful to know:**

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Please accept my application for the EDGE – DAY RETREAT. I understand that I must abide by the rules and regulations set forth by the Youth Ministry Team. I understand that no alcohol, tobacco or illegal drugs are allowed in my possession on this trip.

**Teen's Signature:** \_\_\_\_\_

**Parent or Guardian's Signature:** \_\_\_\_\_

I request that my son/daughter be allowed to attend St. Helen's **EDGE - DAY RETREAT** to be held at **ST. HELEN TEEN CENTER** on **Saturday, February 25, 2012 from 8:00 am until 5:30 pm.**

- Students are asked to arrive at the TEEN CENTER at **8:00am**
- Mass begins at 8:30 am
- **RETREAT ENDS at 5:30 pm**

- I, the undersigned, have read and understand all reasonable precautions will be taken by those in charge to prevent injuries. I will not hold St. Helen's Church, the Diocese of Phoenix, or any adult advisor responsible in case of accident.

**INFORMATION ABOVE IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE**

Parent or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_