



The Health Form for Diocese of Southern Virginia

Retreat Weekends for children, youth, and adults

11827 Canon Blvd., Suite 101, Newport News, VA 23606 757-423-8287

Name _____

Date _____

The following information must be filled in by the parent/guardian or adult leader. The intent of this information is to provide diocesan representative health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Please provide complete information so that we are aware of any health concerns.

★★★ IMPORTANT – This section must be complete for attendance. ★★★

- I consent and give permission for Diocese of Southern Virginia’s medical personnel and designated staff to administer authorized medication, first aid, and/or emergency treatment to me and/or my child. In addition, I give permission and consent to Diocese of Southern Virginia’s medical personnel and/or staff to provide or arrange transportation for me and/or my child and to select and consent to health care providers evaluating, testing, treating and/or hospitalizing me and/or my child when, in their opinion, such services are needed. I also consent to the release of medical records and medical information in order to secure medical care and/or payment for medical services.
- This completed form may be photocopied for Diocesan events.

Signature of parent/guardian/adult leader _____

The participant has the following medication allergies (please describe the reaction and the management of the reaction).

Drug Allergy	Reaction and Management/Treatment

The participant has NO KNOWN FOOD ALLERGIES

The participant has the following food allergies (please describe the reaction and the management of the reaction).

Food Allergy	Reaction and Management/Treatment

Other Allergies: (please list – include hay fever, asthma, animal dander, and special sensitivities to insect stings, poison ivy, etc.)

Allergy	Reaction and Management/Treatment

OVER

Medications

- This person brought NO medication to take while at camp.
- This person brought the following medication to take while at camp:

Note: Please list all medications to be taken routinely and as needed, including prescription and over-the-counter. Keep all medication in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

Medication Name	Dosage	Frequency	Reason for taking	For nurse use only
				8:30a 1p 6:30p Bed
				8:30a 1p 6:30p Bed
				8:30a 1p 6:30p Bed
				8:30a 1p 6:30p Bed
				8:30a 1p 6:30p Bed
				8:30a 1p 6:30p Bed

Restrictions

- There are NO restrictions for this individual.
- The following restrictions apply to this individual:

Restrictions on Activity _____

Restrictions on Diet (list foods and why) _____

If any restrictions, this section must be signed by participant.

Signature of participant/leader: _____ **Date signed:** _____

Signature of parent/guardian if attendee is a minor: _____ **Date signed:** _____

**** Please note:** We will need a fresh copy of this form every time you come to an event. The only time this form has to be re-completed is when something has changed with your care. Questions? Contact the Diocese at 757-423-8287.