ARCHDIOCESE OF LOS ANGELES

HEALTH FORM

St. CORNELIUS CATHOLIC CHURCH; 5500 E WARDLOW RD LONG BEACH CA 90808 (562)421-8966

Candidate Name_____ **Date of Birth** _____**Female** _____**Male**_____

Address_____ **City** _____**Zip**_____ **Phone** (____)_____

Participant is in general good health & able to participate in all activities: **YES**_____**NO** _____ (if no, list limitations on back)

ALLERGIES: (please write **yes** or **no** next to each)

HAY FEVER_____ **ASTHMA**_____**POISON IVY** _____**SULFA**_____ **CONVULSIONS**_____

PENICILLIN_____ **BEE STING**_____ **SEIZURES**_____ **DIABETIC**_____ **OTHER**_____

If any of the above is yes, please submit a statement of how the child has been treated and with what medication.

Operations or Serious Injuries:_____ **Dates:**_____

Vegetarian Diet Requested _____ **(yes or no) Special Dietary Needs**_____

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I/We, the undersigned, parent(s) / guardian(s) of _____, a minor, do hereby authorize **Cristy Hull or other St. Cornelius Staff Member,** as agent 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 is given to provide authority and power on the part of our for said agent to give specific consent to any 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 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 that are listed on the back of this form. I understand that the Director of this event will dispense any medications so listed.

This authorization is given pursuant of the provisions of section 25.8 of the civil code of California.

This authorization shall remain effective from **September 1, 2020 to August 30, 2021**

Signature of Parent(s) / Guardian(s):_____ **Date:**_____

Telephone During Event (_____)_____**Cell Phone (_____)**_____

Another person to contact in case of emergency:_____**Phone (____)**_____

Family Health Insurance Co:_____ **Policy #:** _____