



Diocese of Rochester  
Youth Registration / Health Form 2021-2022

LAST NAME:	_____	FIRST NAME:	_____
ADDRESS:	_____		
CITY:	_____	STATE:	_____ ZIP: _____
HOME PHONE:	_____	CELL PHONE:	_____
EMAIL:	_____	GRADE:	_____ SEX: F <input type="checkbox"/> M <input type="checkbox"/>
PARISH:	_____	LOCATION:	_____

<b>MOTHER'S INFORMATION:</b>	<b>FATHER'S INFORMATION:</b>
NAME: _____	NAME: _____
WORK PHONE: _____	WORK PHONE: _____
CELL PHONE: _____	CELL PHONE: _____
EMAIL: _____	EMAIL: _____
ADDRESS: _____	ADDRESS: _____
<i>*IF DIFFERENT FROM TEEN</i>	<i>*IF DIFFERENT FROM TEEN</i>

<b>EMERGENCY CONTACT IF PARENT / GUARDIAN IS NOT AVAILABLE:</b>	
NAME: _____	RELATIONSHIP: _____
HOME PHONE: _____	CELL PHONE: _____

HEALTH INSURANCE CO: _____	POLICY NUMBER: _____
PRIMARY CARE PHYSICIAN: _____	PHYSICIAN PHONE #: _____

List any allergies or special needs/concerns/ dietary restrictions, health concerns:	List any medications (prescription and non-prescription) currently taking, including dosage:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

My child can receive the following medications from the Program Coordinator if needed: (please check boxes below).		
ASPIRIN YES <input type="checkbox"/> NO <input type="checkbox"/>	ACETAMINOPHEN YES <input type="checkbox"/> NO <input type="checkbox"/>	IBUPROFEN YES <input type="checkbox"/> NO <input type="checkbox"/>
I give permission for the Diocese of Rochester to make use of pictures of my child for informational/advertising purposes only for Diocesan programs. YES <input type="checkbox"/> NO <input type="checkbox"/>		

<b>Event Information (If Applicable):</b>	
EVENT NAME: _____	EVENT DATE: _____

**\*\*PLEASE TURN OVER TO COMPLETE THE FORM\*\***



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COVID-19 Screening

<b>Does your child have a new cough that cannot be attributed to another health condition?</b>	YES / NO
<b>Does your child have new shortness of breath that cannot be attributed to another health condition?</b>	YES / NO
<b>Does your child have a new fever (100.4°F or higher) or chills that cannot be attributed to another health condition?</b>	YES / NO
<b>Does your child have any of the following symptoms?</b> <i>Fatigue   New loss of taste or smell   Muscle or body aches   Congestion or runny nose   Headache   Nausea or vomiting   Sore throat   Diarrhea</i>	YES / NO
<b>Has your child come into close contact (within 6 feet) with someone who has a laboratory-confirmed COVID-19 diagnosis in the past 14 days?</b>	YES / NO

I hereby certify that the above information is correct and that my child exhibits no signs of COVID-19 and is not currently infected or has been infected with COVID-19 in the past 30 days. I give permission for my child to be transported in privately-owned vehicles for medical emergencies only, and for the release of medical records to an attending healthcare professional in case of illness. I understand that every effort will be made to contact the parent/guardian. If one cannot be contacted, I hereby give permission for a qualified physician to secure proper treatment for my child.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_