



Diocese of Rochester
Youth Registration / Health Form 2024-2025

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: _____

<p><i>MOTHER'S INFORMATION:</i></p> <p>NAME: _____</p> <p>WORK PHONE: _____</p> <p>CELL PHONE: _____</p> <p>EMAIL: _____</p> <p>ADDRESS: _____</p> <p><i>*IF DIFFERENT FROM TEEN</i></p>	<p><i>FATHER'S INFORMATION:</i></p> <p>NAME: _____</p> <p>WORK PHONE: _____</p> <p>CELL PHONE: _____</p> <p>EMAIL: _____</p> <p>ADDRESS: _____</p> <p><i>*IF DIFFERENT FROM TEEN</i></p>
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EMERGENCY CONTACT IF PARENT / GUARDIAN IS NOT AVAILABLE:	
NAME: _____	RELATIONSHIP: _____
HOME PHONE: _____	CELL PHONE: _____

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

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

Event Information (If Applicable):	
EVENT NAME: _____	EVENT DATE: _____

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



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COVID-19 Screening

Does your child have a new cough that cannot be attributed to another health condition?	YES / NO
Does your child have new shortness of breath that cannot be attributed to another health condition?	YES / NO
Does your child have a new fever (100.4°F or higher) or chills that cannot be attributed to another health condition?	YES / NO
Does your child have any of the following symptoms? <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
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?	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: _____