Diocese of Rochester
Youth Registration / Health Form 2025-2026

LAST NAME: _____ FIRST NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ CELL PHONE: _____
EMAIL: _____ GRADE: _____ SEX: F ☐ M ☐
PARISH: _____ LOCATION: _____

MOTHER'S INFORMATION:

NAME: _____
WORK PHONE: _____
CELL PHONE: _____
EMAIL: _____
ADDRESS: _____
**IF DIFFERENT FROM TEEN*

FATHER'S INFORMATION:

NAME: _____
WORK PHONE: _____
CELL PHONE: _____
EMAIL: _____
ADDRESS: _____
**IF DIFFERENT FROM TEEN*

EMERGENCY CONTACT IF PARENT / GUARDIAN IS NOT AVAILABLE:

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:

1. _____
2. _____
3. _____
4. _____
5. _____

List any medications (prescription and non-prescription) currently taking, including dosage:

1. _____
2. _____
3. _____
4. _____
5. _____

My child can receive the following medications from the Program Coordinator if needed: (please check boxes below).

ASPIRIN YES ☐ NO ☐	ACETAMINOPHEN YES ☐ NO ☐	IBUPROFEN YES ☐ NO ☐

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 ☐ NO ☐

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? *Fatigue | New loss of taste or smell | Muscle or body aches | Congestion or runny nose | Headache | Nausea or vomiting | Sore throat | Diarrhea*	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: _____