



HELLENIC ORTHODOX COMMUNITY CHURCH OF ST. GEORGE

ALSO KNOWN AS

ST. GEORGE GREEK ORTHODOX CHURCH

45816 Woodward Avenue, Bloomfield Hills, MI 48032

(248) 335-8869, Rev. Father Nicholas Pathenos



GREEK ORTHODOX YOUTH OF AMERICA (G.O.Y.A.)

HEALTH AND MEDICAL INFORMATION FORM

The parent/legal guardian of a child who is registered to attend G.O.Y.A. activities must complete this form for your child to participate. This is to ensure that appropriate care is given, if and when needed, during G.O.Y.A. activities. At a minimum, this form should be reviewed yearly to ensure no changes have occurred. Please initial and date the form after each review.

Child's Name: _____ Birth Date: _____

Address: _____ Gender: () Male () Female
Street City State ZIP

Name of custodial parent/legal guardian(s): _____
(Please Print)

Home Address: _____

(If different from above) Street Address City State ZIP

Father: Daytime Phone (____) ____ - ____ Evening Phone (____) ____ - ____ Cell Phone (____) ____ - ____

Mother: Daytime Phone (____) ____ - ____ Evening Phone (____) ____ - ____ Cell Phone (____) ____ - ____

If not available in an emergency, notify: Name: _____ Relationship: _____

Address: Phone: (____) ____ - ____
Street City State ZIP

Insurance Information: Is the participant covered by family medical/hospital insurance? Yes () No ()

If so, indicate carrier or plan name: _____ Group # _____

(PLEASE INCLUDE PHOTOCOPY OF THE INSURANCE CARD)

Name and phone number of personal physician and practice: _____

I (we) give permission for above named minor to receive any emergency treatment* (medical or surgical) and to receive basic medication or first aid from the adults on a trip. I (we) will assume responsibility for any such medical expenses incurred. The adults may administer: _____ Aspirin _____ Tylenol _____ Ibuprofen

*Medication: Please list and indicate below any medications your child must take during the time of this treatment, if any.

This minor takes no medications on a routine basis.

This minor takes medications as follows (list names, dosages, and times):

Medication #1: _____ Dosage _____ Specific times each day _____

Describe reaction (s) and management of the reaction and reason for taking:

Medication #2: _____ Dosage _____ Specific times each day _____

Describe reaction (s) and management of the reaction and reason for taking:

Medication Allergies

Food allergies (list all known)

#1 _____

#2 _____

My (our) child has been vaccinated for: _____ tetanus (give date of last booster) _____

List any dietary or physical restrictions, or other medical conditions (check where applicable) your child may have:

__ rheumatic fever __ asthma __ diabetes __ motion sickness __ heart problems __ seizure disorder __ urinary tract difficulties

__ difficulty getting along with peers or authority figures (explain): _____

__ other problems leading to unconsciousness (explain): _____

__ any recent medical care received? (explain): _____

Signed (Father): _____

Signed (Mother): _____

Date

Date