

MEDICAL INFORMATION

Student's name _____ **Birth date** _____

Address _____ **Home phone #** _____

Business phone where parents can be reached :

Mother (first & last name) _____ # _____

Father (first & last name) _____ # _____

Friend of family (first&last) _____ # _____

Does your child have any medical condition or have any medical history that we should know of? Yes _____ No _____

If so, please specify: _____

Does your child have/take any medication (prescription or over the counter) that we should know of? Yes _____ No _____

If so, please specify: _____

Is your child a Jehovah's Witness? **Yes** _____ **No** _____

Do you have any religious objections to certain types of medical assistance? **Yes** _____

No _____

Specify _____

Does your child have food/medication allergies? **Yes** _____ **No** _____

Specify _____

Does your child have medial insurance? **Yes** _____ **No** _____

If so:

Insurance co. _____ Policy # _____

Insurance co. address: _____

Doctor's name: _____ office # _____

Does Your Child Suffer From Asthma? Yes _____ No _____

Emergency Contact:

Name: _____

Phone: _____

Relation to Student: _____

In the event of a medical emergency, I authorize the school sponsor to make the necessary decisions for the safety of my child's health.

Father's signature _____

Mother's signature _____

Guardian's signature _____

Date _____

PLEASE INCLUDE A LEGIBLE COPY OF BOTH SIDES OF YOUR CHILD'S
MEDICAL INSURANCE CARD