

STUDENT MEDICAL INFORMATION

CONTACT INFORMATION:

Student's Name: _____

Address: _____ Date of Birth: _____

Student's Social Security #: _____

Dads Name _____ Moms Name _____

Dads Address if different from student: _____

Moms Address if different from student: _____

Dads Employment: _____ Dads Work Phone: _____

Dads Home Phone _____ Dads Cell Phone: _____

Moms Employment: _____ Moms Work Phone: _____

Moms Home Phone _____ Moms Cell Phone: _____

If parents can not be reached, call this person: _____

Day Phone: _____ Night Phone: _____

INSURANCE/MEDICAL INFORMATION

Insurance Company: _____ Policy # _____

Medication student is currently taking: _____

Reason: _____

Allergies: (Check all that apply) _____ Asprin _____ Penicillin _____ Sulfa
_____ Insect Stings _____ Tetracycline _____ Food (specify) _____
_____ Other (specify) _____

Health History: (Check all that apply) _____ Diabetes _____ Orthopedic Problems _____ Asthma
_____ Epilepsy _____ Cardiac Problems _____ Other (Specify) _____

Do we have permission to administer to the above student (check): _____ Asprin _____ Tylenol

Date of last tetanus shot: _____

I give permission to the physician or hospital to secure proper treatment for and to order medications, injections, anesthesia or surgery for the student as named above. If an emergency arises, I understand it might be necessary for my child to receive medical care before I can be contacted:

Signature _____ Date: _____