

# MEDICAL INFORMATION

PLEASE PRINT

Student's Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Last First Middle

Sex M F Date of Birth \_\_\_\_\_  
(Circle one)

Parents' Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Number-Dad \_\_\_\_\_ Cell Number-Mom \_\_\_\_\_

Address \_\_\_\_\_ Subdivision \_\_\_\_\_  
Street City Zip

EMERGENCY TELEPHONE AND CONTACT'S NAME \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

## TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Physician \_\_\_\_\_ Physician's Telephone \_\_\_\_\_

Does the student have previous history of: (Circle one)

Bleeding tendencies	Yes	No	Now under a physician's care	Yes	No
Head injuries, seizures	Yes	No	Date of last Tetanus shot	Yes	No
Asthma	Yes	No	Allergy	Yes	No
High Blood Pressure	Yes	No	Neck Injury	Yes	No
Tuberculosis	Yes	No	Bone and/or joint injury	Yes	No
Sickle Cell Anemia	Yes	No	Heart Disease	Yes	No
Kidney Disease and/or Injury	Yes	No	Diabetes	Yes	No
Kidney, Lung, or Eye removed or Non functioning	Yes	No	Surgical Operation	Yes	No
Hepatitis	Yes	No	Allergy to Medication	Yes	No
Rheumatic Fever	Yes	No	Contact Lens/Glasses	Yes	No
Skin Disease	Yes	No			

Is the student taking medication regularly Yes No

Explain any "yes" answers \_\_\_\_\_

Please List all medications and any illnesses not listed above requiring medication being taken at the present time \_\_\_\_\_

I hereby consent for medical care to be given to \_\_\_\_\_ in case of an emergency.

\_\_\_\_\_  
Parent/Guardian Signature

**MY CHILD HAS PERMISSION TO TAKE  
ADVIL AND/OR TYLENOL FOR ACHES/PAIN  
(circle one)  
YES NO DOSAGE: \_\_\_\_\_**