MEDICAL INFORMATION
(PLEASE PRINT)

Student's Name: _____

Sex: M F Date of Birth: _____

Parents Names: _____

Cell Number Parent 1: _____ Cell Number Parent 2: _____

Address: _____
Street City Zip

Emergency Contact Name and Cell Number: _____

Insurance Company _____ Policy Number: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Physician: _____ Phone Number: _____

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

Bleeding tendencies	yes/no	Now under physician's care	yes/no
Head injuries, seizures	yes/no	Allergy	yes/no
Asthma	yes/no	Neck injury	yes/no
High Blood pressure	yes/no	Bone and/or joint injury	yes/no
Tuberculosis	yes/no	Heart disease	yes/no
Sickle Cell Anemia	yes/no	Diabetes	yes/no
Kidney Disease and/or injury	yes/no	Surgical Operation	yes/no
Kidney, Lung or Eye removed or Non functioning	yes/no	Allergy to medication	yes/no
Hepatitis	yes/no	Contact lenses/glasses	yes/no
Rheumatic Fever	yes/no		
Skin Disease	yes/no		
Is student taking medication regularly:	yes/no		

Explain any yes answers:

_____
_____
_____
_____

Please list any medications and illnesses not listed above that require medication being taken at the present time:

_____
_____

I hereby consent for medical care to be given to: _____ in case of emergency.
My child has permission to take Advil and/or Tylenol for aches/pain: yes/no dosage: _____

Parent/Guardian Signature: _____