Medical Information Form

Full Legal Name: ____

Street Address: __________________________________City: __________________State: ________________

Zip Code: _____________

Social Security Number: (Required for treatment at most hospitals) __________________________________

Date of Birth: _____________________ Age__________________ Grade: ____________________________

List all Allergies or medical conditions that would impact treatment:

____

____

Medications taken on a regular basis: ____

Name of Parents or Legal Guardian: ____

Street Address: _______________________________City: _____________________State: _______________
Zip Code: _______________

Home Phone: ____________________________ Business Phone: ________________________

Cell Phone: ____________________________

List Two Other Emergency Contacts

1) Name & Phone Number: ____
2) Name & Phone Number: ____

Name of Primary Insurance Policy Owner: ____

Insurance Company & Address: ____

Policy Number: ____

Secondary Insurance Policy Owner: ____

Insurance Company & Address: ____

Policy Number: ____

I hereby give permission for authorized personal of (**School Name**) ___________________ to grant permission for medical treatment for my child, (**Child's Name**) ____________________, if I am not readily available, and I authorize the physician and such other health care provider selected by (**School Name**) _________________to render such emergency medical treatment as deemed necessary under the circumstances.

Parent or Legal Guardian: ____

Print Name: _________________________________ Signature: _________________________________

Date: ____________________________________