# Medical Information

Student Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

**In Case of Emergency, please notify:**

Name: _____ Relationship: _____

Phone – Home: _____ Cell: _____ Work: _____

**Alternative Emergency Contact:**

Name: _____ Relationship: _____

Phone – Home: _____ Cell: _____ Work: _____

**Primary Care Physician:**

Name: _____

Address of Office: _____

Phone: _____

Please check the following areas of concern:

1) Allergies: ( ) Hay Fever ( ) Drugs, please list ( ) Asthma
   ( ) Food, please note which foods ( ) Bee Sting
   ( ) Other Problems: (Note)
2) Does student suffer from, or ever experienced, or has currently tested positive for:
   ( ) Epilepsy/Seizure Disorders ( ) Heart Trouble ( ) Diabetes
3) Does student wear contact lenses? ( ) yes ( ) no
4) Does child/youth/minor take regular medications?
   Prescription Medications: (Note prescriptions taken daily) _____
   Non-Prescription: (Note over the counter medications taken daily) _____

**Medical/Hospital Insurance Information:**

Insurance Co.: _____

Phone: _____ Policy No.: _____

Policy Holder's Name: _____

Relationship to student: _____

If unable to contact a parent or guardian at the time of an injury, I give permission for this student to be taken to the nearest hospital for emergency treatment.

Signature of Parent/Guardian _____ Date _____