



MEDICAL INFORMATION

Health History of: _____ Gender: Male _____ Female _____

Date of Birth: D _____ /M _____ /Y _____ Height: _____ Weight: _____

Health Number: _____

Please comment on you child's overall health: _____

If your child is unable to participate in athletic and/or school activities, please outline:

Has this child ever had an eye test? Yes/No _____ Result: _____

Has this child ever had a hearing test? Yes/No _____ Result: _____

Does this child have allergies? Yes/No _____ Specify: _____

Is this child considered anaphylactic? Yes/No _____

Is this child currently taking medication? Yes/No _____ Specify: _____

If yes, what is the purpose of the medication? _____

Does the student need to keep medication at school? Yes/No _____ Specify: _____

Name of Physician: _____ Telephone: _____

Address: _____

Please give the name and number of 2 persons who can be contacted in case of an emergency, when parents cannot be reached:

Name: _____ Relationship: _____

Address: _____ Telephone: _____

Name: _____ Relationship: _____

Address: _____ Telephone: _____

Consent Form:

In case of emergency resulting from an accident or illness where prompt medical attention is deemed necessary and the parents cannot be immediately contacted, permission is hereby given to take the above-mentioned child to the nearest medical facility and proceed with medical treatment. I understand that any medical expenses incurred for such treatment are my responsibility.

Parents Signature: _____ Date: _____