Medical/Insurance Form

Name____ Date ________________________

DOB ___________________________________ Age _______ Grade _________________

Medical Conditions____

Current Meds _____________________________ Dosage ___________________________

Shots current Yes _______ No __________ Medical allergies _________________________

Prior Surgeries ____

Insured Guardian Name____

Address: ____

Home Ph: ________________ Cell ______________ Work ___________________________

Address: ____

Home Ph: ________________ Cell ______________ Work ___________________________

Insurance Company ____

Policy # ___________________________________ ID# ___________________________________

Phone# ____

My child can be given OTC Tylenol or Motrin if needed: ___ Yes ___ No, please call me first.

Any other important information:

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