



Personal Health and Medical Record for

To be filled out by parent or guardian. Please print in ink. **Date** _____

IDENTIFICATION

Name _____ Date of Birth _____ Age ____ Sex ____

Parent(s)/Guardian(s) _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Father's work _____ Father's cell _____

Mother's work _____ Mother's cell _____

If person named above is not available in the event of an emergency, notify:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name of personal physician _____ Phone _____

Hospital preference _____

Permission is given for school administrator to give the following over-the-counter medication(s):

Please list approved medications: _____

Personal health/accident insurance carrier _____

Policy No. _____ Group No. _____

A copy of my insurance card is attached. (Required, if applicable)

Date of last tetanus immunization _____

I give permission for full participation in school events and/or athletic programs.

In case of an emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date _____ Signature of parent/guardian _____

Please include instructions about special medical needs, food allergies, current medications child is taking or considerations here (use the back if necessary):
