MEDICAL INFORMATION FORM

Child's Name _____ Age ____ Gender _____

Name of Doctor _____ Phone _____

Name of Dentist/Orthodontist _____ Phone _____

Do you carry family medical/hospital Insurance? YES NO

Name of parent/person with insurance policy _____

Health Insurance Agency Name _____

Policy #_____Group #_____

Medications currently taking: _____

_____

_____

Allergies/Medical conditions: _____

_____

_____

_____

Date of last Tetanus shot? _____

Is your child under the care of a physician for:

Epilepsy? YES NO

Diabetes? YES NO

Other_____

_____

I understand that this contract will be reviewed regularly every six months and will remain for an indefinite period.

PARENT/GUARDIAN'S NAME (Please print)

_____

PARENT/GUARDIAN'S SIGNATURE

_____ DATE_____