MEDICAL INFORMATION FORM

Student's full name____ M_______ F_______
Address ____ Date of birth ______________
City ____ Zip __________________________
Emergency Contact #1 ________________________________ Relation _____________ Phone _____________
Emergency Contact #2 ________________________________ Relation _____________ Phone _____________
Emotional problems (hyper-ventilator, homesickness, etc) ____
____
Serious medical problems ____
____
Allergies ____
Prescription medications ____
Any special health problems in the past ____
Allergy to drugs (specify) ____
Medication presently taking (include anti-convulsive, antihistamine, insulin, tranquilizer, allergy, pain, etc.)
____
Is student under medical treatment at present time? __________ Reason _______________________________
Doctor ____ Phone ________________________

Any additional health information ____
____

This is permission for treatment of above named student by physician or at a hospital in case of emergency.

INSURANCE COMPANY ____

Policy # ______________________________________ Group # ______________________________

ATTACH A COPY OF THE FRONT AND BACK OF INSURANCE AND DENTAL CARDS TO THIS PAGE .

I have read, and I understand and support the rules and regulations of St. John Paul II. I consent that my child or guardian has read the rules and regulations and will do his/her best to comply with all of these rules and regulations. It is understood that the signature on this document of one parent or guardian implies consent of the other.

____ Date ________________________
Parent/ Guardian Signature