Morningside Baptist Church

1560 Pedrick Road, Tallahassee, Florida 32317

Medical Information Form

(Please print or type all information)

Date ____/____/____

1. Name of Youth_____________________________________D.O.B.________________

S.S.# _________________________________

2. Address_____________________________________zip________Ph#______________

3. Parent's (Guardian's) Name ____

Business Phone _______________________ Cell Phone _____________________

Father/Mother place of business ____

4. Family member or friend to be contacted if parents cannot be reached:

Name________________________Relationship____________ Ph#____________

5. Name of Physician _____________________________________Ph#_______________

6. Is your child currently covered by health insurance? Yes_____ No_____

Name of Company _______________________Policy# ______________________

7. Does your child have a chronic illness ? Yes_____ No _____

If yes, explain ____

8. Allergies? Yes _____ No_____ If yes, explain __________________________________

____

9. Allergic reaction to medication? Yes _____ No_____ If yes, give name(s) of medications

____

10. Any physical restrictions which limit activity? Yes_____ No_____ If yes, explain _______

____

11. Any adverse reactions to anesthesia? Yes_____ No_____ If yes, explain _____________

____

12. Any history of seizures? Yes_____ No_____ If yes, how often and what kind? _________

____

13. Are you presently taking any medication? Yes _____ No_____ If yes, what kind(s)? _____

____

(All medication taken by your child must be described in writing, including name of medicine, dosage amount, how
And when it is to be administered, and must be given to the assigned minister prior to departure.)

14. Any history of diabetes? Yes _____ No_____ If yes, explain _____________________

____

15. Date of last tetanus shot ________________

16. Other helpful Information ____