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: ____

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____

Allergies/Medical conditions: ____

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____

____

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______________