

Medical Information Form

Last Name:		Fir	rst Name:		
D.O.B. (mm/dd/yyyy)	Ag	e	Grade	Gender M()F()	
Address:	City/State/Zip:				
Name of Parent			email		
Home Phone ()					
Address:					
Name of Parent			_email		
Home Phone ()					
Address:		City/S	State/Zip:		
Child lives with					
Emergency Contact			Relationship		
Name of contact					
Home Phone ()					
Address:		City	//State/Zip:		
Health History: (Please check any o	of the belo	ow that ap	oply)		
1. Fainting or dizziness?	Yes	No			
2. Passed out/had chest pain during exercise?	Yes	No_No			
3. Have recurrent/chronic illness?	Yes	_No			
If yes, please list any info you choose to share:					
4. Have asthma/wheezing/shortness of breath?	Yes	_No			
If yes, do they carry an inhaler?	Yes	_No			
5. Have diabetes?	Yes	No			
If yes, do they carry insulin?	Yes	_No			
6. Had seizures?	Yes	_No			
7. Wear glasses, contacts, or protective eyewear?_	Yes	No			
8. Have allergies to foods?		No			
Have allergies to medications?	Yes	No			
If yes, please list allergies:					

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder ((AD/HD)?	Yes	
2 From home transfer of for any time of an home district				No
2. Ever been treated for emotional or behavioral di	fficulties?		Yes	
4. Had a significant life event that continues to affe (History of abuse, death of a loved one, family change, ad			Yes	No
Please explain "Yes" answers in the space below			r additio	nal
information.		,		
Insurance Information				
Personal physician's name	Ph# ()			
r croonar priyorcian o name				
Medical insurance company	Policy number _			
Name of primary insured				—
I, the legal guardian of the above-named minor, authorize they see necessary. I consent to any x-ray, anesthetic, me necessary by a licensed health care provider during the paspecific diagnosis, treatment or hospital care, and that it is licensed health care provider the authority to administer	dical or surgical diagnosis or treatment and hospital car articipant's session. I understand that this authorizatior s given to provide the VCC staff authority to seek medic this treatment as s/he judges necessary to the above-na	re subsequently den n is given in advanc cal treatment, and t amed child. I accep	emed e of any to provide t	a
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