

MEDICAL HISTORY FOR ANY HOSPITAL OR PRACTITIONER

Please complete the following in its entirety and return.

YOUTH'S NAME: _____

YOUTH'S AGE: _____

YOUTH'S GRADE LEVEL: _____

PARENT/GUARDIAN INFORMATION

Mother's Name: _____
Mother's Phone: _____ (Home) _____ (Work) _____ (Cell)

Father's Name: _____
Father's Phone: _____ (Home) _____ (Work) _____ (Cell)

Guardian's Name: _____
Guardian's Phone: _____ (Home) _____ (Work) _____ (Cell)

Emergency Contact: _____
Relationship: _____
Emergency Phone: _____ (Home) _____ (Work) _____ (Cell)

YOUTH INFORMATION

Allergies: _____
Medication being taken: _____
Date of last tetanus shot: _____
Physical Impairments: _____
Other health issues the Physician should be aware of: _____

Family Physician: _____
Address: _____
Phone: _____

Medical Insurance Co.: _____
Policy Number: _____
Subscriber's Name: _____