CUMC Youth Medical Information Form

Please print in ink

Name: _____ Age _____ Birthday _____
LAST FIRST MIDDLE

Year in school _____ Male Female Email _____

Address _____ City _____ State _____ Zip _____

Phone _____ Pager / cell _____

Medical insurance company _____ Policy # _____

Mother's name _____ Phone: Home _____ Work _____

Father's name _____ Phone: Home _____ Work _____

Emergency contact _____ Phone: Home _____ Work _____

Physician _____ Office phone _____

Dentist _____ Office phone _____

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

Check the following areas of concern for this student. If necessary, add another page with details:

1. For your child's safety and our knowledge, is your student a—
   good swimmer fair swimmer non-swimmer
2. Does your child have allergies to—
   pollens medications food insect bites

3. Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:
   asthma epilepsy / seizure disorder heart trouble diabetes
   frequently upset stomach physical handicap

4. Date of last tetanus shot: _____

5. Does your child wear glasses contact lenses

6. Please list and explain any major illnesses the child experienced during the last year:

   Additional comments:

   Should this child's activities be restricted for any reason? Please explain:

Form Completed by:

_____ _____
Parent/Guardian Signature Date Signed