FC 2020 Medical Form

Student Info

Full Name _____

DOB _____ Age _____ M / F Grade Fall 2020_____ Cell Phone _____

Address _____ City _____ State _____ Zip_____

Father/Guardian _____ Mother/Guardian _____

Cell Phone _____ Cell Phone _____

Email _____ Email _____

List Medications: List Reasons for Taking Medication:

_____ _____

_____ _____

_____ _____

_____ _____

List Allergies:

_____ _____

_____ _____

Date of Student's Last Tetanus Shot: _____

Physician's Name _____ Phone _____

Insurance Company _____ Policy # _____

Phone # _____

Emergency Contact _____ Emergency Contact _____

Relationship _____ Relationship _____

Cell # _____ Cell # _____

In case of accident or serious illness, parents/guardians/relatives/friends will be contacted. If parents/guardians/relatives/friends cannot be contacted, and the above named needs emergency medical treatment, consent is hereby granted for such emergency treatment as may be considered necessary in the opinion of the attending physician. Authorization is also given for any of the listed medications on this form to be administered, if necessary, to the above named individual.

Signature _____ Date _____

Parent/Guardian (for students under 18 years of age)