

# FC 2019 Medical Form

## Student Info

Full Name \_\_\_\_\_ Cell Phone \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

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)