Medical Information Form

Full Legal Name: _____

Street Address: _____City: _____State: _____

Zip Code: _____

Social Security Number: (Required for treatment at most hospitals) _____

Date of Birth: _____ Age_____ Grade: _____

List all Allergies or medical conditions that would impact treatment:

_____

_____

_____

Medications taken on a regular basis: _____

Name of Parents or Legal Guardian: _____

Street Address: _____City: _____ State: _____
Zip Code: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____

List Two Other Emergency Contacts

1) Name & Phone Number: _____
2) Name & Phone Number: _____

Name of Primary Insurance Policy Owner: _____

Insurance Company & Address: _____

Policy Number: _____

Secondary Insurance Policy Owner: _____

Insurance Company & Address: _____

Policy Number: _____

I hereby give permission for authorized personal of Bible Baptist Christian Academy to grant permission for medical treatment for my child, (**Child's Name**) _____, if I am not readily available, and I authorize the physician and such other health care provider selected by Bible Baptist Christian Academy to render such emergency medical treatment as deemed necessary under the circumstances.

Parent or Legal Guardian: _____ Date: _____

Print Name: _____ Signature: _____