SOUTH GREENE BAND OF REBELS MEDICAL INFORMATION

Full Name: _____ Birthday: _____

Social Security Number: _____

Insurance Provider: _____

Group/Account#: _____ Policy#: _____

Primary Care Physician: _____

Physician's Phone: _____

In case of emergency, I authorize school personnel to obtain medical services for my child:

_____ _____

Parent/legal guardian name Signature

Date Signed: _____

Please list all medications the student takes regularly:

_____

_____

_____

Please provide a complete history of all major illness, injuries, or treatments:

_____

_____

_____

Please list all known medical and food allergies:

_____

_____

_____

Other important information you wish to include:

_____