Personal Medical History
for _____

Name: **Date of Birth:**

Address:

Parents Names:

Mother's Phone numbers: Home: Work: Cellular:

Father's Phone number's: Home: Work: Cellular:

Previous Medical Conditions:

Doctor(s) Name	**Phone Number**	**Address**
1.		
2.		
3.		

Current Medications	**Medication Allergies**
1.	1.
2.	2.
3.	3.

Food Allergies	**Other Allergies**
1.	1.
2.	2.
3.	3.

Emergency Contact

Name:

Phone Number:

In the event that I am not able to dictate my own/my child's medical treatment, and my emergency contact is not able to be reached, I give Dionne Luxford permission to do so for me.

Signed: Date:

Printed: Relation to person:

Parent or legal guardian signature required if student under 18.