Mentee Medical History

Name of Primary Care Physician: _____Phone No: (_____)_____
Medical Insurance Provider: _____ Policy Number: _____
Insurance Provider's Phone No. : (_____)_____
Does your daughter have any physical problems or limitations? ( )No ( )Yes If yes, please describe them:

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Is your daughter currently receiving treatment for any medical condition or other challenges? ( )No ( )Yes If yes, please explain:

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Is she currently on any type of medication? ( )No ( )Yes If yes, please explain:

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Does your daughter have any known allergies or adverse reactions to medications? ( )No ( )Yes If yes, please explain:

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Are there any other medical challenges or limitations that we need to know about? ( )No ( )Yes If yes, please explain:

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Does your daughter have any emotional issues or problems right now? ( )No ( )Yes If yes, please explain:

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Is your daughter currently seeing a counselor or therapist? ( )No ( )Yes If yes, please explain:

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