



# Samaritan Fellowship

## 2019 Medical Information Form

Student's Name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Male or Female \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parents Names (Legal Guardians) \_\_\_\_\_

Relation \_\_\_\_\_ Phone \_\_\_\_\_

Relation \_\_\_\_\_ Phone \_\_\_\_\_

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Emergency Contact (Other than Parents/Guardians) \_\_\_\_\_

Relation \_\_\_\_\_ Phone \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_

Contract/Policy Number \_\_\_\_\_

**<<Please include a copy of the front and back of your insurance card>>**

Previous Surgeries \_\_\_\_\_

Taking Medication(s): Yes \_\_\_ No \_\_\_ Name(s) of Medication(s) \_\_\_\_\_

Asthma: Yes \_\_\_ No \_\_\_ Current Treatment \_\_\_\_\_

Allergies: Yes \_\_\_ No \_\_\_ Current Treatment \_\_\_\_\_

Special Needs / Health Concerns  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_