Morningside Baptist Church
1560 Pedrick Road, Tallahassee, Florida 32317
Medical Information Form

Please provide all information and return to Morningside office or youth minister.

Date ____/____/____

1. Name of Youth_____ D.O.B. ____/____/____

S.S.# _____ - _____ - _____

2. Address:_____ Zip:_____ Ph# ( )____- _____

3. Parent's (Guardian's) Name: _____

Business Phone (if applicable): ( )____- _____ Cell Phone: ( )____- _____

Father/Mother place of business: _____

4. Family member or friend to be contacted if parents cannot be reached:

Name: _____Relationship: _____ Ph# ( )____- _____

5. Name of Physician: _____ Ph# ( )____- _____

6. Is your child currently covered by health insurance? Yes ___ No ___

Name of Company: _____Policy#: _____

7. Does your child have a chronic illness? Yes___ No ___

If yes, explain: _____

8. Allergies? Yes ___ No ___ If yes, explain: _____

_____

9. Allergic reaction to medication? Yes ___ No___ If yes, give name(s) of medications:

_____

10. Any physical restrictions which limit activity? Yes___ No___ If yes, explain: _____

_____

11. Any adverse reactions to anesthesia? Yes ___ No ___ If yes, explain: _____

_____

12. Any history of seizures? Yes ___ No ___ If yes, how often and what kind? _____

_____

13. Are you presently taking any medication? Yes ___ No ___ If yes, what kind(s)? _____

_____

(All medication taken by your child must be described in writing, including name of medicine, dosage amount, how and when it is to be administered, and must be given to the assigned minister prior to departure.)

14. Any history of diabetes? Yes ___ No ___ If yes, explain: _____

_____

15. Date of last tetanus shot: ____/____/____

16. Other helpful Information: _____

_____