 **Print/Type**

**Medical History**

**Student Name:** Cell Phone #: ( )

Home Address:

 Street City State Zip

Home Phone #: ( ) Date of Birth:

Doctor’s Name: Phone:

**Subscriber’s Name**: Policy Number:

 (Person who has insurance policy)

Address:

 Street City State Zip

Employer: Phone: ( )

**Father’s Name:**  Job Title:

 (If different from above)

Work Address:

 Street City State Zip

Employer: Phone: ( )

**Mother’s Name:**  Job Title:

 (If different from above)

Work Address:

 Street City State Zip

Employer: Phone: ( )

**Student’s Health Insurance Coverage** (If possible, please include a copy of your insurance card.)

Insurance Company: Policy #:

Allergies:

Other Necessary Medical Information:

If a parent/guardian cannot be reached in case of an emergency, contact:

Name: Phone: ( )

Parent/Guardian Signature: