Medical Information Form

Name:	ID#:
Address:	E-mail:
	Phone:

Age:	Height:	Weight:	Date of Birth:

Contact Lenses or Dental Appliances:

Chronic Medical Conditions/Concerns:

Current Medical Conditions/Concerns:

Disabilities (Physical, emotional or learning):

Allergies (including medications and latex products):

Current medications, homeopathic treatment or vitamins taken on a regular schedule:

Personal Physician (Name, Address, Phone):

Person to contact in case of emergency (Name, Phone):

Student Signature:	Date: