

OFFICE USE ONLY

Entry Date: _____

Entered By: _____

Expiration Date _____

Grade 2007-2008: _____

**St. Mark
YOUTH
Medical Form
(PLEASE PRINT)**

Youth Name: _____ Sex (circle one) M F Birth Date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____

Parent/Guardian Name: _____ Parent Cell Phone: _____

If you are unable to reach me, contact: _____

Relationship to my son/daughter: _____

Home Phone: _____ Daytime Phone: _____

Please fill out the information below:

Insurance Carrier: _____ Policy Number: _____

Insurance Company Address: _____

Insurance ID Number: _____ Social Security #: _____

Specific Medical Information:

Allergic reactions (medications, foods, plants)

Date of last Tetanus

Medications Currently Taking

I grant permission for the following non-prescription medications to be given to my youth:

Clearly name the drug and quantity to be administered

Any physical limitations or special medical needs

To the best of my knowledge, my child _____ is in good health, and I assume all responsibility for the health of my child. In the event of a medical emergency, I give permission to administer treatment and/or to transport my child to a hospital for emergency medical treatment by a physician. I wish to be advised immediately prior to any further treatment by the hospital or doctor.

Parent/Guardian Signature

Date

