

FAMILY MEDICAL INFORMATION

St. Paul's Lutheran Youth Groups

2008-2009

This authorization shall remain effective for the duration of the year beginning 7/1/2008 and ending 9/30/2009. (Medical information needs to be updated as necessary for the youth)

Youth's Name _____ Age _____ DOB _____

School _____ Grade (2008-2009) _____

FINANCIALLY RESPONSIBLE PERSON:

Name _____ Signature _____

Driver's License # _____ State _____

Home Address _____ City/State/Zip _____

Phone _____ Other phone # _____ E-mail address _____

FAMILY HEALTH INSURANCE INFORMATION WHICH COVERS YOUR YOUTH:

Insurance Company _____

Policy Subscriber's Name _____

(father, mother, guardian)

Policy # _____ Group # _____ Member # _____

Claim's Address _____ City/State/Zip _____

Member Benefits/Service Phone # _____

IN CASE OF EMERGENCY and parents/guardian can't be reached, contact:

Name _____ Phone _____

Address _____ Relationship _____

MEDICAL INFORMATION

Date of last Tetanus shot _____

Known Allergies to food/medications _____

Medications currently taking: (list name, reason, directions) _____

Hospital Preferred _____

Doctor _____ Phone _____

Other medical information that might be useful: (physical problems, recent surgeries, etc.)