Health Form

Student Name: ____

Parent Name: ____

Home Address:____

____

Phone #: _____________________

Insurance Company: ___________________________________

Address: ____

____

Phone #: _______________________

Policy #: _______________________

Child's allergies and/or medications:

____

Any other injuries or conditions we should be aware of: ___________

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____

I give my permission for my child to receive medical attention.

Parent Signature ___________________________Date __________