

This form is only needed for students with medical concerns.

MEDICAL AND ALLERGY INFORMATION

Student's name: \_\_\_\_\_

Class: \_\_\_\_\_

Parent's name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Numbers:

Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Phone numbers: \_\_\_\_\_

Important medical information: \_\_\_\_\_

\_\_\_\_\_

Food allergies (please list): \_\_\_\_\_

\_\_\_\_\_

Parent signature: \_\_\_\_\_

Date: \_\_\_\_\_

Comment [K1]:

Submit the completed form to the Program Director