

Medical History Card

Name : _____

Address: _____

Age : _____ Birthdate : _____

Medical Insurance No. _____

Parents/Guardian Names : _____

Address : _____

Home Phone : _____

Business Phone : _____

Alternate Contact : _____

Home Phone : _____

Business Phone : _____

Illnesses in Past 5 years: _____

Asthma Diabetes Heart Disease
 Recurring Headache Seizures Blackout
 Chest Pain Other Illness or Surgery

Does your child require corrective lenses : Yes/No

Physicians Name: _____

Physicians Phone: _____

Immunization Year of Last Tetanus shot : _____

Allergies or regular Medication: _____

Date Card Completed : _____

Date Updated : _____

All Information is Confidential

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