

HEALTH FORM
Saint Paul School of Theology
Please Print

Participant _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Sex _____ Height _____ Weight _____

Social Security Number _____

Parent(s)/Guardians(s) _____

MOTHER - _____

FATHER - _____

Address (if different from above)

Address (if different from above)

Phones:

Phones:

Home _____

Home _____

Work _____

Work _____

Cell (s) _____

Cell (s) _____

Alternate emergency contact:

Name _____

Phone(s) _____

Health Insurance information: **Include/Attach a copy of the health insurance card**

Name of company _____

Policy number _____ Group number _____

In whose name is the insurance _____

Family doctor _____ Phone _____

Health History:

Medical conditions we need to know: _____

Allergies: _____

Present Medications: _____

Uses corrective eye glasses? Yes No Wears contacts? Yes No

Date of last tetanus _____

PERMISSION FOR MEDICAL TREATMENT

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I (we) cannot be reached, I give permission for medical treatment to the physician or dentist selected by the staff of Saint Paul School of Theology.

I understand that my insurance coverage will be used as primary coverage for any medical treatment.

Parent Signature _____

Date _____