

First Baptist Church of Sarasota, Florida
Medical Information For The Entire Period September 1, 2017 – August 31, 2018

Name _____ Date of Birth _____ Age _____

Street Address _____

City _____ State _____ Zip Code _____

In case of emergency notify _____ (C) (H) (W) _____

Family physician _____ Tel. No. _____

Health insurance company _____ Policy No. _____

Prescription insurance company _____ Policy No. _____

Pharmacy name _____ Tel No. _____

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Medical history

List all current prescription medications and dosages: _____

List all current vitamins, supplements, over-the-counter products, etc.: _____

Known allergies - Yes ___ No ___ If yes, to what? Medication _____

Describe symptom(s) _____ Food _____

_____ Rash/hives/itching _____ Environment _____

_____ Redness/swelling _____

_____ Throat swelling/difficulty breathing _____

_____ Behavior change _____ Blood Type _____

Treatment _____ Date of last tetanus booster _____

Does your child suffer from any of the following?

Yes No

___ ___ Asthma – Treatment _____

___ ___ Seizures (Fever ___ Epileptic _____) – Treatment _____

___ ___ Diabetes – Treatment _____

___ ___ Dizziness – Treatment _____

___ ___ Heart trouble – Treatment _____

___ ___ Headaches – Treatment _____

___ ___ Bronchitis – Treatment _____

___ ___ Sinusitis – Treatment _____

___ ___ Upset stomach – Treatment _____

___ ___ Kidney trouble – Treatment _____

Other relevant medical information _____

I certify all of the above information is correct as of _____, and promise I will advise Tim Storck

in writing of any change(s)

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