Please be sure to fill in all blanks or this form will be returned to your school. Thank You.

SCHOOL: _____

LOUISIANA FAMILY, CAREER AND COMMUNITY LEADERS OF AMERICA, INC.
MEDICAL INFORMATION FORM

INSTRUCTIONS: Fill in all blanks.

Student: _____ Parent/Guardian: _____

Home Address: _____ _____ _____
Street Address City Zip

Phone: (Home) _____ (Work) _____

Alternate Contact: _____ Relationship: _____

Address: _____ _____ _____
Street Address City Zip

Phone: (Home) _____ (Work) _____

Family Doctor: _____ Phone: _____

Family Hospitalization/Accident Insurance Company: _____

Insurance Policy Number or Medical Card Number: _____
(If medical insurance is not available, please indicate on the line above and also complete the Medical Information Form–Attachment

Please describe completely any medical condition (past or present) being treated that may recur or be a factor in medical treatment (include allergies, medicine reactions, disease of any kind, physical handicaps, heart or lung problems, seizures, convulsions, blackouts, etc.) If currently taking medication, state the medication, instructions for taking the medicine and prescribing physician and phone number.
Enter Medical Information below

_____

_____

_____

_____

_____

We certify that the information described above is accurate and complete to the best of our knowledge.

INSTRUCTIONS: Please check your preference for medical treatment and sign below.

☐ I GIVE permission for immediate medical treatment (as required) by the attending physician.

☐ I DO NOT GIVE permission for medical treatment until I have been contacted.

Parent/Guardian Signature _____ Date _____

Revised 12/2006

Please be sure to fill in all blanks or this form will be returned to your school. Thank You.