MECHINA MEDICAL INFORMATION

APPLICANT

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Father's *(or guardian's)* Cell: _____ Mother's *(or guardian's)* Cell: _____

Father's Email: _____ Mother's Email: _____

Person to be contacted in an emergency if parent cannot be reached: _____

Relationship: _____ Phone Number: _____

Physician or Primary Care Provider: _____ Phone Number: _____

Address: _____

IT IS IMPORTANT THAT WE HAVE YOUR ACCURATE INSURANCE INFORMATION!

Please affix a copy of the front and back of your son's insurance card.

Front of card

Back of card

MEDICAL INFORMATION

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

Will your insurance cover medical care in Maryland? ☐ Yes ☐ No

Please list any medications taken on a regular basis: _____

Please list any allergies that you have: _____

Please list any surgeries, serious illnesses or hospitalizations you have had: _____

Please list any medications to which you are allergic: _____

Are you presently consulting a psychologist, psychiatrist, and/or social worker? ☐ Yes ☐ No

If yes, please include Name & Phone Number: _____

PARENTAL

FOR STUDENTS UNDER 18:

I give permission for such diagnostic, therapeutic and operative procedures as may be deemed urgent and necessary by the resident physician or health-care professional, to be performed for my son, _____

Signature: _____

Relationship: _____ Date: _____

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