

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: \_\_\_\_\_

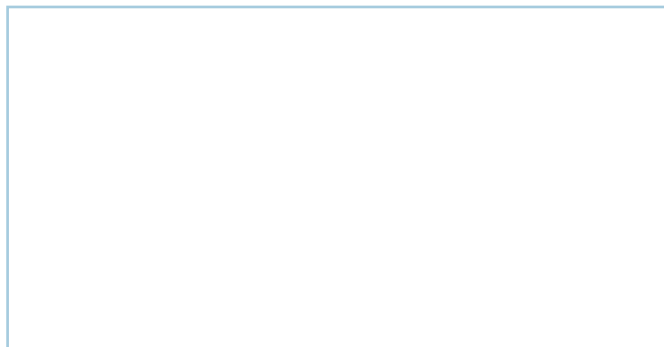
Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Physician or Primary Care Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_

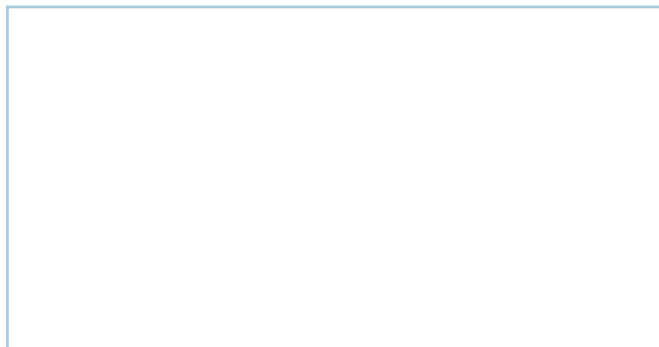
Address: \_\_\_\_\_

## 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

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: \_\_\_\_\_

## 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: \_\_\_\_\_