

KUMC MEDICAL AND CONTACT INFORMATION FORM (YOUTH – UNDER 18)

Please attach a copy of insurance and any prescription cards to this form

Name of child: _____ Sex: Male Female

Date of Child's Birth: ___/___/_____ Age: _____ Grade: _____ School: _____

Address: _____

Home Phone: _____ Your Cell/Pager: _____

Work Phone: _____ email: _____

Mother's Name: _____ Daytime phone: _____

Father's Name: _____ Daytime phone: _____

Add'l Emergency Contact: _____ Phone: _____ Relation: _____

PCP/Doctor's Name: _____ Doctor's Phone: _____

Medical Insurance Co. _____ Member Name: _____

Member ID #: _____ Group #: _____

Child's Medical Conditions:

Asthma? Yes No Activity Limitations: _____

Allergies (food, medicine, etc): _____

Medications currently taking: _____

Medical Conditions: _____

Is there any other medical or health care related info that Klein UMC should know about your child?

Signed by: _____ Relation to Child: _____

Name Printed: _____ Date: _____