

## The Salvation Army Boys & Girls Club MEDICAL INFORMATION FORM

(Please Print)

Today's date:			Youth's Name:			
<b>PATIENT INFORMATION</b>						
Parent's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: (    )	
P.O. Box:		City:		State:	ZIP Code:	
Occupation:		Employer:			Employer phone no.: (    )	
List allergies:	Medication:		Food:		Bee Sting:	
Current Meds						
List Significant Health Problems:						

<b>INSURANCE INFORMATION</b>						
(Please give your insurance information.)						
Youth's Name:		Birth date: / /	Address (if different):		Home phone no.: (    )	
School:	Grade:	Physicians Name & Address:			Physicians phone no.: (    )	
Is this youth covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Welfare (Please provide more info:)		<input type="checkbox"/> Other	
Subscriber's name:		Youth's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

<b>IN CASE OF EMERGENCY</b>				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: (    )	Work phone no.: (    )
I give my/our consent for the release of the above information and consent to medical treatment if necessary by a physician of a hospital. I understand The Salvation Army is not responsible for personal injury. I give my permission for the staff to perform first aid.				
_____ Patient/Guardian signature			_____ Date	