SECOND CHILD

2026-2027 Medical Information – Completed by parent or Legal Guardian
Please Print

Child's Name____ Birth date ___ /___ /______

Child's Soc.Sec.No.* ____

Allergies ____

Medications ____

Chronic Conditions (e.g. epilepsy, diabetes) ____

Family Doctor ____ Phone No. ___________________

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Medical Insurance Co ______________________________. Policy No. ______________________________

Policy Holder's Name ____

Phone No. (h)________________________ (w)_________________________ (c)____________________

Birth date ____ / ____ / ______ Soc.Sec.No.* _______________________________________

* Social Security Number is optional. Please note that some hospitals WILL NOT treat without it. You may use your driver's license number in place of SS number but it may not be accepted by medical institution for treatment to take place.
(See Activity Information form)

SPECIAL MEDICAL INSTRUCTIONS &/OR INFORMATION PERTAINING TO THIS CHILD, write below:
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THIRD CHILD

2026-2027 Medical Information – Completed by parent or Legal Guardian
Please Print

Child's Name____ Birth date ___ /___ /______

Child's Soc.Sec.No.* ____

Allergies ____

Medications ____

Chronic Conditions (e.g. epilepsy, diabetes) ____

Family Doctor ____ Phone No. ___________________

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Medical Insurance Co _____________________________. Policy No. _____________________________

Policy Holder's Name ____

Phone No. (h)________________________ (w)_________________________ (c)____________________

Birth date ____ / ____ / ______ Soc.Sec.No.* _______________________________________

* Social Security Number is optional. Please note that some hospitals WILL NOT treat without it. You may use your driver's license number in place of SS number but it may not be accepted by medical institution for treatment to take place. (See Activity Information form)

SPECIAL MEDICAL INSTRUCTIONS &/OR INFORMATION PERTAINING TO THIS CHILD, write below:
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