

Medical Information Form Ysleta Lutheran Mission

This form must be completed by all participants. One copy should be carried with the group leader.
This form must be signed by parent or guardian of participants under 18 years of age.
Please type or print legibly in ink.

Participant Name: _____
(Last) (First) M.I.

Birth date: / / Male: Female: _____

Home address: _____

City/State/Zip _____

Home phone: () Day phone: () _____

Custodial parent/guardian: _____

Home phone: () Day phone: () _____

Home address (if different): _____

Health plan carrier: _____

Name of insured: _____

Relationship to participant: _____

policy holder or insurance ID number: _____

Family doctor: _____ Office phone: () _____

Family dentist: _____ Office phone: () _____

Second parent or emergency contact person: _____

Relationship to participant: _____

Home phone: () Day phone: () _____

Please specify if any health insurance precertification, notification, or other requirements exist for the participant: _____

For the following questions, circle yes or now. If yes, please explain in the lines given.
Does participant have:

Headaches	Yes	No
Seizures	Yes	No
Motion sickness	Yes	No
Fainting	Yes	No
Sleep walking	Yes	No
Upset stomach	Yes	No

