Health Fact Sheet

Name: _____

Date of Birth: _____   Age today: _____

Social Security Number:_____

Address: _____

_____

Home Phone: _____

Parent/Guardian Home Phone: _____

Parent/Guardian Cell Phone: _____

Primary Car Physician Name: _____

Primary Care Physician Phone: _____

Primary Care Physician Address: _____

Pharmacy Name: _____

Pharmacy Phone: _____

Medical History

Any allergies or chronic conditions such as asthma: _____

_____

List any allergies to medication: _____

_____

List date and type of any previous surgeries: _____

_____

Any medications your child takes regularly, including vitamins, minerals, herbs or supplements, alcohol or illegal drugs: _____

_____

Insurance Information

Insurance Company Name: _____

Insurance Company Policy Number: _____

Insurance Company Member Number: _____

Insurance Company Member Name: _____

Update as needed – date last completed:

*This information is not to be used in lieu of any required forms for physician or hospital, rather it is in case of an emergency where someone does not have access to their cell, purse or wallet – where something has happened such as an automobile accident, a fire, a flood or other emergency.