Medical Information Form

<u>Please fill this form out carefully. Print clearly.</u>

NAME OF STUDENT:____

ADDRESS:

____

CITY: __________________________________ STATE: ______ ZIP: _________

DATE OF BIRTH: ________________SEX: ______ HEIGHT: ______WEIGHT: _____

PARENT OR LEGAL GUARDIAN NAME (S):

____

ADDRESS:

____

CITY: __________________________________ STATE: ______ ZIP: _________

HOME PHONE: (   )_________________ WORK: (   )____________________

FAMILY DOCTOR NAME:____

ADDRESS:

____

CITY: __________________________________ STATE: ______ ZIP: _________

PHONE: (   )_____________________________

Please give us the name of your health/accident insurance carrier (s) and appropriate policy certificate number (s):

NAME OF CARRIER: ____

CARRIER'S PHONE NUMBER: ____

CERTIFICATE NUMBER:____

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Please fill this form out carefully. Print clearly.

Does this student have any chronic or acute medical problems? YES NO

If YES, please explain:

____

____

____

List any allergies to food, pollen, or medicine:

____

____

List any medications being taken at present time:

____

____

MEDICAL RELEASE FORM

My son/daughter does have permission to attend *The Championship Debate Group* on the campus of Concordia University in Austin, TX. I fully realize that injury or illness to my son/daughter could result from or during participation in the institute. In case of such accident or illness, I give permission for my child to be given medical treatment as deemed appropriate. I will assume responsibility for any medical bills incurred by my child while attending *The Championship Debate Group*.

____ ____________________

Parent or Legal Guardian Signature   Date