

Medical Information

Physician's Name: _____ Phone(____) _____ - _____

Address: _____ city _____ zip code _____

List any food/drug allergies, special needs, and/or medical conditions: _____

List any medications regularly taken: _____

Date of last physical examination: _____

Child's social security number: _____ - _____ - _____

I certify this child is in good health and can attend Cornerstone Academy.

Physician's signature: _____ date _____

Insurance company: _____ phone (____) _____ - _____

Policy number: _____

I authorize Cornerstone Academy to obtain emergency medical care for my child
(name) _____ and to transport the child for emergency reasons.

_____ signature date _____

* All children must keep a current shot record on file.

Office use only:

Date received: _____

Shot record on file: _____ date

Staple copy of updated shot records to this form as needed