

Confidential Medical Questionnaire

Full Name		Birthdate
Address	City	State
Social Security Number		Home Number
Mother's Work Phone	Father's Work Phone	
Doctor's Name (in Salem)		Phone
Name of Medical Insurance Company		
Mailing Address of Said Company		
Policy or Group Number		Phone
If neither parent/guardian can be reach in an emergency, please indicate who to call		
Name		Phone
Relationship		

Please answer ALL of the following questions and give any other pertinent medical information.

- a Yes a No 1. Are you presently under treatment for any medical problems?
a Yes a No 2. Do you take any medication(s) routinely? If so, what?

- a Yes a No 3. Have you ever been unconscious or had any head injuries?
Please explain _____
- a Yes a No 4. Are you allergic to any medications or certain types of food?
Please explain _____
- a Yes a No 5. Have you ever had asthma, hay fever, hives, or eczema? (If answering
"yes", have a more-than-ample supply of medications with you.)
- a Yes a No 6. Do you have a history of diabetes or heart disease?
a Yes a No 7. Have you had any recent illness, skin rashes, or sore throats?
Please explain _____
- a Yes a No 8. Do you require any injections (allergy or other) on a regular basis?
Please explain _____
9. Date of last Tetanus shot _____
10.

Parent/Guardian(s) Signature _____ **Date** _____