OVERNIGHT MEDICAL ADDENDUM 2017-18

(Valid until Dec. 31, 2018)

Student's Name: _____

Doctor: _____ Phone #: _____

Dentist: _____ Phone #: _____

Allergies? Yes No Please describe: _____

Past hospitalizations/surgeries? Yes No Please describe: _____

_____

Pre-existing Medical conditions? Yes No Please describe:_____

_____

Currently taking medications? Yes No Please list and explain dosage:_____

_____

Legal Guardian Name:_____

Signature:_____

Date: _____

Please attach a photocopy of your child's insurance card.