OVERNIGHT MEDICAL ADDENDUM 2019-20

(Valid until Dec. 31, 2020)

Student's Name: ____

Doctor: ______________________________ Phone #: ______________________

Dentist: ______________________________ Phone #: ______________________

Allergies? Yes No Please describe: ________________________________

Past hospitalizations/surgeries? Yes No Please describe: ________________

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

____

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

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Legal Guardian Name:____

Signature:____

Date: ________________________

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