St. Peter's UMC
Individual Medical Form
PLEASE FILL OUT ALL LINES

Name _____ Birthdate _____

Soc. Sec. # Do Not Need Social Security Number

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Parents Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

In Case of Emergency notify _____

Home Phone _____ Work Phone _____ Cell Phone _____

2nd Contact _____

Home Phone _____ Work Phone _____ Cell Phone _____

Family Physician _____ Phone _____

Medical Insurance

Provider Name _____ Number _____ Group Number _____

Billing Address _____

Medical History (Attach any explanation on a separate sheet)

_____ Epilepsy _____ Kidney Trouble _____ Seasonal Allergies

_____ Asthma _____ Heart Trouble _____ Stomach Upsets

_____ Sinusitis _____ Headaches _____ Dizziness

_____ Bronchitis _____ Diabetes

Other _____

Date of last tetanus shot _____

Current Medications (include dosage/time) _____

Allergies

Food _____

Medicine _____

Insect Stings/Bites _____ Poison Sumac, Oak or Ivy _____

Other _____

Current Mediations (Include dosage/time) _____

My child may/maynot be given Tylenol

Childhood Diseases

_____ Chickenpox _____ Measles _____ Mumps _____ Whooping Cough

Other _____

Any known reasons for restricted activity _____

Previous operations or serious illnesses (give details) _____