



UNIVERSITY OF
MARY HARDIN-BAYLOR
EDUCATION FOR LIFE... EXPERIENCE OF A LIFE-TIME

Medical Information

Please print, using black or blue pen

YOUR CHILD'S INFORMATION			
Child's Last Name:	Child's First Name:	Child's Preferred Name:	Child's Date of Birth:
Parent or Legal Guardian's Name:		Cell Phone (including area code):	Email Address:
Address/City/State/Zip:		Home Phone (including area code):	Work Phone (including area code):
Emergency Contact (other than parent or legal guardian):		Emergency Contact's Cell Phone:	Emergency Contact's Email:

YOUR CHILD'S MEDICAL HISTORY		
<i>UMHB will not administer medication or provide medical treatment. In an emergency, basic first responder care may be provided.</i>		
I affirm that my child's required immunizations are current		List medication currently being taken and their purpose
<input type="checkbox"/> YES (Attach immunization record, required for participation)		Medication:
		For what reason?
List any medical conditions your child has (i.e. seizures, diabetes)		1.
		2.
		3.
		4.
		5.
List allergies (medicine, food, environment, contact, etc.) and reaction.		Special safety instructions for your child:
Allergen	What happens?	
1.		
2.		
3.		

YOUR CHILD'S MEDICAL INSURANCE	
<i>THIS IS FOR MEDICAL EMERGENCY PURPOSES ONLY. UMHB DOES NOT BILL YOUR INSURANCE COMPANY FOR ITS SERVICES. UMHB assumes no responsibility for medical expenses incurred by you or your child and strongly recommends that SNL participants maintain individual medical insurance.</i>	
Medical Insurance Company:	Primary Care Physician Name: Office Phone #:
Medical Insurance Company Address/City/State/Zip:	Medical Insurance Company Phone (Member Services #):
Policy Number:	Group Number (if applicable):