SOUTHEASTERN ACADEMY
MEDICAL INFORMATION #5

PLEASE FILL THIS FORM OUT AND RETURN TO THE OFFICE AS SOON AS POSSIBLE SO WE MAY BETTER SERVE YOUR CHILD(S) NEEDS.

GRADE_____

STUDENT FIRST _____

STUDENT LAST _____

PARENT LAST NAME_____

TITLE_____(EX. (MR & MRS), (DR. & MRS.) ETC...

FATHER'S FIRST_____

MOTHER'S FIRST_____

ADDRESS_____

CITY_____

STATE_____

ZIP_____

HOME PHONE_____

WORK PHONE_____

CAR PHONE_____

EMERGENCY NAME_____EMERGENCY PHONE_____

EMERGENCY NAME_____EMERGENCY PHONE_____

PHYSICIAN_____PHONE_____

DENTIST_____PHONE_____

OPHTHALMOLOGIST_____PHONE_____

MEDICAL CONDITION _____

_____

_____

MY CHILD IS ALLOWED TO TAKE OVER-THE-COUNTER MEDICATION OFFERED BY THE SCHOOL _____YES _____NO

PARENT OR LEGAL
GUARDIAN SIGNATURE_____DATE_____