UGA BAPTIST COLLEGIATE MINISTRIES
ANNUAL MEDICAL FORM

Full Name ________________________ **Sex** _______ **Birthdate** _______________ **Age** _______

School Address: ____

City: ____________________________________ State: _______ Zip Code ______________________

Cell Phone: _____________ Email Address: ______________________ Classification: FR SO JR SR GR

Parent(s) or Guardian(s)

Name: _________________________ Home Address: ____

City: ____________________________________ State: _______ Zip Code ______________________

Cell Phone: ______________ Other Phone Number: ________________ Email: _____________________

Emergency Contacts: *If not available in an emergency, notify:*

1. Name: ____ Relationship: ________________________

   Phone _________________ Other Phone Number: ____________________

2. Name: ____ Relationship: ________________________

   Phone _________________ Other Phone Number: ____________________

Physician Information:

State the name, addresses, medical specialty and phone number of your family physician who should be consulted in the event of emergency or medical problems.

Name: ____ Phone ____________________

Medical Specialty: ____

Street Address: ____

City: ______________________________ State: _______ Zip Code _________

Insurance Information:

Do you have medical or hospitalization insurance which provides benefits? ☐ Yes ☐ No

If so, please indicate:

Name of Insurance Co.: ____

Phone Number of Insurance Co.: ____________________________________

Insurance Policy Number: ____

(Continued on Back)

Health information:

Food allergies: ____ Special Food Needs: _________________

Other Allergies: _____________________________ If you have allergy, do you carry an Epi Pen? _______

Past Medical History (Please indicate if you have had any of the following):

__ Asthma __ Bronchitis __ Sinusitis __ Kidney Trouble

__ Heart Trouble __ Diabetes __ Hay Fever __ Insect Bites/Stings

__ Poison Sumac/Ivy __ Stomach Problems __ Dizziness __ Allergies: _________________

If you check any box above, please give us details: ____

____

Previous Operations or Serious Illnesses: ____

____

Please list all medications you are currently taking: ____

____

Children's Diseases (Please indicate if you have had any of the following):

__ Chicken Pox __ Whooping Cough __ Measles __ Mumps __ Other: ____________________

Immunizations (Please indicate if you have had any of the following immunizations):

__ Tetanus (Year: _______) __ Measles __ Polio Booster __ Mumps

Are there any activities (i.e. strenuous activities) to be restricted for you? ☐ Yes ☐ No

If so, describe: ____

____

Please list any other medical issues or history we should be aware of: ______________________________

____

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I understand that this information is given in order that Baptist Collegiate Ministries can assist me in obtaining care if needed. This information is to be kept confidential and will not be shared with any other entity.

Signature ____ Date _______________