MEDICATION CHECK IN

Please PRINT all information

Name of Cadet _____
Last First

Medications you are turning in

Name of Medication	Dosage (MG)	Time of take meds taken (Morning, Noon, Evening)

Does your child have medical insurance? Yes _____ No _____

Name of insurance provider _____ **Policy #** _____

(We will contact you later if we do not have a copy of your insurance card)

Private Insurance claims require policy holder's date of birth

Name of Policy Holder	Date of Birth	Social Security Number

Any Allergies? _____

_____

Any major medical diagnosis or concerns? (Ex: ADD, ADHD, Bipolar, Epilepsy, Hernia, Scoliosis ect.)

_____

_____

Guardian's Printed Name _____

Guardian's Signature _____ Date _____