SOUL SCHOOL - MEDICAL SCREENING

STUDENT NAME **DATE OF BIRTH**

KNOWN ALLERGIES

CURRENT MEDICAL CONDITIONS

DIETARY RESTRICTIONS

EMERGENCY CONTACTS

NAME **PHONE NUMBER**

NAME **PHONE NUMBER**

ALTERNATIVE TRUSTED ADULTS AUTHORIZED FOR PICKUP

NAME **PHONE NUMBER**

NAME **PHONE NUMBER**

PRIMARY DOCTOR

NAME **PHONE NUMBER**

PREFERRED LOCAL HOSPITAL OR MEDICAL FACILITY

FACILITY NAME