

# Virtuosi of Houston Medical Information Certificate

Please Print

Student's Name: \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_ Age \_\_\_

Parent(s) or Guardian Name: \_\_\_\_\_ Student's Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Parent(s) or Guardian Telephone \_\_\_\_\_ Emergency Telephone \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Family Physician \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Does the student have a previous history of:

	Yes	No		Yes	No
Bleeding tendencies	_____	_____	Asthma	_____	_____
Hernia	_____	_____	High Blood Pressure	_____	_____
Tuberculosis	_____	_____	Sickle Cell Anemia	_____	_____
Kidney Disease and/or injury	_____	_____	Hepatitis	_____	_____
Rheumatic Fever	_____	_____	Skin Disease	_____	_____
Contact Lenses/Glasses	_____	_____	Allergy	_____	_____
Neck injury	_____	_____	Bone and/or joint injury		
Heart Disease	_____	_____	or disease	_____	_____
Kidney, Lung, or Eye			Diabetes	_____	_____
Removed or non-functioning	_____	_____	Surgical operation	_____	_____
Head injuries, seizures			Is student taking		
unconsciousness,			medication regularly	___	___
concussion, convulsion	_____	_____	Allergy to medicine	_____	_____
			Date last tetanus shot	_____	_____

Explain any "yes" answers \_\_\_\_\_

Now under a physicians care? \_\_\_ Yes \_\_\_ No

Name and phone of Physician \_\_\_\_\_

Please list all medications and any illnesses not listed above requiring medication being taken at the present time \_\_\_\_\_

I hereby consent for medical care to be given to \_\_\_\_\_ in case of an emergency.

You warrant and represent that You have the right, power and authority to sign this release on behalf of Your Minor.

Date: \_\_\_\_\_

By: \_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Printed signature