



# Member Information Form

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School Address: \_\_\_\_\_ Home Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

## PARENT/GUARDIAN CONTACT INFORMATION

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

## MEDICAL INFORMATION (OPTIONAL)

Any health conditions, allergies, etc.? \_\_\_\_\_

Current Medications: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Office Phone #: \_\_\_\_\_

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

Preferred Hospital: \_\_\_\_\_

Health Insurance Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_