**HEBRON UNITED PRESBYTERIAN CHURCH**
**10460 FRANKSTOWN ROAD**
**PITTSBURGH, PA 15235-2998**
**Phone: 412-371-2307 Fax: 412-371-0146**
**Email: jzeils1422@aol.com**

**NAME**_____
**LAST FIRST MIDDLE**

**SEX**_____**AGE**_____**BIRTH DATE**_____
**MONTH DATE YEAR**

**ADDRESS**_____

**CITY**_____**STATE**_____**ZIP CODE**_____

**ALLERGIC REACTION TO MEDICATION**_____

**DIETARY RESTRICTIONS**_____

**OTHER RESTRICTIONS**_____

**ALLERGIES**_____**HAY FEVER**_____**INSECT STINGS**_____**ASTHMA**_____

**LAST TETANUS SHOT**_____/ _____/ _____ **(MUST BE WITHIN TEN YEARS)**

**FAMILY PHYSICIAN**_____**PHONE NO.**_____

**PARENT/ GUARDIAN**_____**PHONE NO.**_____

**PARENT'S PLACE OF WORK**_____ **PHONE NO.**_____
**EMAIL NO.**_____

**IN CASE YOU CANNOT BE REACHED, WHO CAN WE CALL?**

**(1)**_____**PHONE NO.**_____

**(2)**_____**PHONE NO.**_____

**HEALTH INSURANCE COMPANY**_____
**SUBSCRIBER**_____
**POLICY NO.**_____

**THE STUDENT IS UNDER THE CARE OF A PHYSICIAN FOR THE FOLLOWING CONDITIONS**
_____
_____

**CURRENT TREATMENT**_____
_____

**PLEASE LIST NAMES, DOSAGE, ADMINISTRATION TIMES & REASONS FOR TAKING ANY MEDICATION PRESCRIBED BY A PHYSICIAN.**
**(1)**_____
**(2)**_____
**(3)**_____

**(Revised 8-13-06)**