



Home Education Activities Teams

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INDIVIDUAL HEALTH/MEDICAL INFORMATION FORM

LAST NAME _____ FIRST NAME _____

GRADE _____ DOB _____ PARENT EMAIL _____

Parent Contact & Phone Number _____

_____ May participate in all HEAT activities

_____ May participate in all HEAT activities except: _____

Medical information pertinent to routine care and emergencies: _____

Is this individual taking prescription or over the counter medications? YES NO If yes, please indicate the names of medications: _____

Does the individual have allergies? YES NO Explain: _____

Is the individual on a special diet? YES NO Explain: _____

Does the individual have special needs? YES NO Explain: _____

Comments: _____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's phone number: _____

Insurance (Insured's Name/Insurance Co./Policy #) _____

Emergency Contact (Name/Phone #/Relationship) _____

Emergency Contact (Name/Phone #/Relationship) _____

Print Parent or Guardian's Name

Parent or Guardian's Signature

Date