2023-2024 Debutante Cotillion and Scholarship Program
Alpha Kappa Alpha Sorority, Incorporated® Eta Omicron Omega Chapter

HEALTH SERVICES INFORMATION FORM

Name of Debutante:_____

Name of Parent or Guardian and Relationship to be contacted in the case of a medical emergency**.**

_____

Telephone number of Parent or Guardian**:** _____

List any chronic medical conditions your teen may have (i.e.: diabetes, asthma, etc.).

_____
_____

Please list all medications that your teen is currently taking and their doses.

_____
_____

Please list any medications/reactions or foods to which your teen has an allergy and describe the reaction (i.e. hives, rash).

Medications	Foods
_____	_____
_____	_____
_____	_____

Please describe any activity restrictions/limitations and any other pertinent medical history.

_____
_____

Please provide the name of your teen's doctor and telephone number.

_____

Name of Insurance Company:_____

Insurance Membership Number:_____