



## Transition to Community Mentoring Program Health Screen Information

Youth's Name: \_\_\_\_\_  
\_\_\_\_\_ Age: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_  
\_\_\_\_\_

Additional Medical Needs (If applicable):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Insurance Information

Medical Assistance Number:

\_\_\_\_\_

Name of Insurance Company:

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Policy Number(s):

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