



MEDICAL CARE AND EMERGENCY CONTACT INFORMATION

Child's Name: _____ Date of Birth: _____

Address: _____

Caregiver/Guardian's Name: _____ (h): _____

(w): _____ (c): _____

Caregiver/Guardian's Name: _____ (h): _____

(w): _____ (c): _____

Alternate Emergency Contact: _____ Phone: _____

Child's Physician: _____ Phone: _____

Known allergies for child (medicine, food, bees, etc.) _____

Describe past serious illnesses or hospitalizations, with dates _____

Medicines currently take by child: _____

Date of last tetanus injection: _____

Describe all physical conditions or illnesses which could affect the child's participation in the School's programs or proper medical treatment (diabetes, epilepsy, poor blood clotting, etc.)

Health Insurance Company: _____ Policy Number: _____

Address: _____ Group Number: _____

Other applicable information you would like to include: _____

