

EMERGENCY MEDICAL INFORMATION

Family Name _____
(List any and all last names in family)
Complete Street Address _____
City _____ State _____ Zip Code _____
Home Telephone _____ Cell Phone _____
Email Address _____

Please complete family insurance information below:
Insurance Carrier _____ Policy No. _____
Group No. _____ Contact Phone _____

Please complete one section for each child. Please sign and date form at bottom.

1.
Child's Name (First & Last) _____
Date of Birth _____ Age _____ Grade _____
Does your child have any special dietary needs? _____ Yes _____ No
If yes, please explain _____

List all prescription medication this child is taking.

2.
Child's Name (First & Last) _____
Date of Birth _____ Age _____ Grade _____
Does your child have any special dietary needs? _____ Yes _____ No
If yes, please explain _____

List all prescription medication this child is taking.

3.
Child's Name (First & Last) _____
Date of Birth _____ Age _____ Grade _____
Does your child have any special dietary needs? _____ Yes _____ No
If yes, please explain _____

List all prescription medication this child is taking.

In the event of a medical emergency, I hereby authorize those in charge to take my child to the nearest licensed physician, medical center or hospital, and to secure necessary treatment, (medications, injections, anesthesia or surgery) to protect my child's well being. I will be responsible for all medical costs not covered by my insurance.

Parent or Guardian Signature _____ Date _____

Date of Meeting with Parent: _____