MEDICAL AND EMERGENCY CARE INFORMATION

NAME OF CHILD_____Age_____Date of birth_____

NAME OF PARENT(S) OR GUARDIAN_____

Home phone_____Work phone_____Alternative #_____

IF PARENT(S) OR GUARDIAN CANNOT BE REACHED, IN CASE OF EMERGENCY CALL:

Responsible Adult_____Day phone_____

1. Any known allergies? Please specify:_____

2. On any medication for any reason? Yes_____ No_____

   If yes, we cannot administer any drug or medication without specific written instructions from the physician or the parent/guardian.

   Please list medications:_____

3. Previous hospitalizations? Yes_____ No_____ Why?_____

4. Any physical handicaps? Yes_____ No_____ If yes, please explain:
   _____

5. Any history of: mental retardation, convulsions, diabetes in family, history of heart trouble? Yes_____ No_____
   If yes to any, please give details:_____

6. Is the child under the care of a doctor? Yes____ No_____
   If yes, please explain:_____

7. Name of physician:_____ Phone_____

8. Name of dentist:_____ Phone_____

9. Hospital preference:_____

Permission is given for the director, teacher or counselor to determine whether a situation requires (1) simple first aid, (2) advice from the designated physician or (3) immediate transport to a medical facility. Permission is given for the director, teacher or counselor to transport the child to the designated hospital or nearest medical facility.

Parent/Guardian signature Date