HEALTH INFORMATION

2020 - 2021

PLEASE PRINT

Child's Name: _____

Age: _____ Date of Birth: _____

Contact Person (local) in case of emergency and person legally responsible cannot be reached:

Name: _____

Phone Numbers (1) _____

(2) _____

Relationship to Child: _____

Doctor's Name: _____

Phone Number: _____

Dentist Name: _____

Phone Number: _____

PLEASE PRINT

Medications / Medical Restrictions:

_____

_____

Allergies: (Medication, Food, Insects, Seasonal & etc.) and / or asthma and specific treatment. What reaction could the child have if exposed to allergen:

_____

_____

I hereby give my consent for the above child to be treated in case of emergency:

Parent Signature: _____Date: _____

Insurance Carrier: _____

Policy Number: _____

****Please attach copy of Health Insurance Card**