

Health & Emergency Information Record

Child's Name: _____

Date of Birth _____ Home Phone _____

Mother's Name: _____

Father's Name: _____

Does your child have any long-term medical conditions that will affect his/her daily routine? _____

Does your child have
Frequent colds _____ Ear aches _____ Stomach aches _____
Asthma _____ Hives _____ Allergic to bee stings _____
Other _____

Does your child have any food allergies _____

Other allergies _____

What symptoms appear related to this allergy? _____

Persons to contact if parents are unavailable

Name: _____ Relationship to child _____

Address: _____ Phone: _____

Name: _____ Relationship to child _____

Address: _____ Phone _____

Child's Physician: _____ Phone: _____

Address: _____

Hospital Preference: _____

Date of last Tetanus booster: _____

Insurance Company: _____

Policy #: _____

In the event that I cannot be reached, I hereby give my permission for my child to receive any necessary emergency medical care or treatment. I understand that every effort will be made to contact me or my spouse before such action is taken. I will be responsible for the payment of such care or treatment.

Signature of Parent/Guardian: _____ Date: _____