

Medical Care and Emergency Contact Information

Child's Name: _____	Birth Date _____
Address _____	
Mother's Name _____	Phone (H) _____ Phone (W) _____
Father's Name _____	Phone (H) _____ Phone (W) _____
Alternate Emergency Contact 1) _____	Phone _____
Alternate Emergency Contact 2) _____	Phone _____
Child's Physician _____	Phone _____
Family Physician _____	Phone _____
Known Allergies of Child (medicine, food, etc.) _____	

Describe past serious illnesses or hospitalization, with dates _____

Medicines taken by child _____

Date of last tetanus injection _____

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

Health Insurance: Company _____ Policy Number _____

Notarized Emergency Medical Treatment Consent

I hereby give _____ permission to provide first aid care for my child, _____ . In the event I cannot be reached, I hereby authorize _____

_____ to transport my child to the emergency room of the hospital(s) listed below,

And I hereby grant my consent for the hospital and its medical staff to provide my child with emergency medical treatment which a physician deems necessary (including anesthesia). If I have not specified any hospital(s) below, my child may be taken to and cared for at the nearest hospital. I agree to accept financial responsibility for all medical expenses incurred.

Hospital _____ Hospital _____
 _____ Nearest Hospital

Parent/Guardian _____	Parent/Guardian _____
Date _____	Date _____

State of: _____

County of: _____

The foregoing Consent was acknowledged before me this _____ day of _____, 20____, by _____ and _____.

(Notary Seal)	Notary Public
My Commission Expires: _____	