MEDICAL INFORMATION FORM

CHILD'S NAME: ____

ADDRESS: ____

PHONE NUMBER: ____

DATE OF BIRTH: ____

PARENTS NAMES:

Mother: ________________________ Father: ______________________

Mother's phone: (h) ____________(w) _______________ (c) ____________

Father's phone: (h) ____________(w) _______________ (c) ____________

EMERGENCY CONTACTS: (OTHER THAN THOSE ABOVE)

NAME: ____

PHONE: ________________________________

RELATIONSHIP:__________________________

PASSWORD: _________________________

*(a secret word that anyone who comes to pick up your child, other than yourself, would know).

NAME: ____

PHONE: ________________________________

RELATIONSHIP:__________________________

PASSWORD: _________________________

*(a secret word that anyone who comes to pick up your child, other than yourself, would know).

MEDICAL DATA:

DOCTOR'S NAME: ____

PHONE #: ______________________________

CHILD'S O.H.I.P#: ________________________

ALLERGIES: (TO WHAT) ____________________________________

(SYMPTOMS) ______________________________________

(LIFE-THREATENING?) YES OR NO (Circle One)

(ACTION REQUIRED) ________________________________

CURRENT MEDICATIONS:

Medication: _____________________Condition: __________________

Medication: _____________________ Condition: __________________