Medical Information Form

Child/ren Name: _____

Child/ren Primary Physician: _____

Primary Physician Contact Information:

Name of Hospital Physician is associated with: _____

Telephone number: _____ Address: _____

Child/ren Health Insurance Policy Number and Provider:

_____

Any Known Allergies or Medical Condition:

_____

List of Current Medications: _____

Authorization for Emergency Treatment: YES or NO

Print Parent Name: _____

Parent Signature: _____

Date: _____

Please attach copy of health card