

MEDICAL INFORMATION

Name _____ Home phone:(_____) _____

Cell phone(s)w/name(s) _____

Address _____

D.O.B. _____ Age _____ Parent's work phone:(_____) _____

Parent(s) name(s) _____ email: _____

Emergency contact/Neighbor _____ phone:(_____) _____

Recent surgery/illness _____ Date _____

Asthma/other limiting conditions _____

Any known allergy to medication _____

Childhood diseases _____

Date of last tetanus shot _____ Home physician _____

Address _____ phone:(_____) _____

Medication to be taken/dosage _____

for the following condition _____

****Major medical insurance carrier _____**

Insurance billing address _____

Subscriber name _____

Subscriber employer & policy # _____

****Each participant must provide their own major medical coverage. There is no medical coverage provided as part of this program.**

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize that medical and/or surgical care be provided for my child. I assume all financial responsibility for this care.

Signature _____ Relationship _____ Date _____

Guardian (Please Print) _____

Additional information _____

REMINDERS: Are there any blank spaces on this form? Please complete.