

****This form is good for one year from date of signature**

Emergency Medical Information

Child's Full Name: _____
City/State/Zip: _____
Home Phone: _____
Birth Date: _____
Father's Work Phone: _____
Mother's Work Phone: _____
Insurance Co: _____
Insurance Card #: _____
Insurance Policy #: _____
Doctor's Name: _____
Doctor's Address: _____
Office Phone: _____
Emergency Phone: _____

Medical History

Has Child Ever Had:	Yes	No
Appendicitis		
Asthma or Hay Fever		
Hernia (Rupture)		
Rheumatic Fever		
Diabetes		
Does Child Take Insulin		
Poliomyelitis		
Heart Trouble		
Scarlet Fever		
Severe Allergies		
Significant Disease, Injury or Operation		
Medical History That Requires Medication		

Any Activity Restricted due to Medical		
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Is Child Subject To:	Yes	No
Sinus Trouble		
Fainting Spells		
Ear Trouble		
Convulsions		
Poison Ivy, Oak or Sumac		
Reaction to Penicillin		
Nervousness/ Easily Upset		
Allergy		

Date of Last Tetanus Shot _____

If answer is "yes" to any question, please explain:

Signature of Parent/Guardian

Date