Emergency/Health Information Form

Name ____ Date __________

Date of birth______________________
Address____
____
Phone number(s)____
____

Emergency/Health Information

Allergies (food, medicines,etc.)__________________________________

Chronic illnesses____

Medications____

Emergency phone numbers:

NAME	PHONE(s)
____________________	____________________________________
____________________	____________________________________
____________________	____________________________________

Insurance Provider/Health Plan________________________________
Health Plan Number____
Preferred Hospital____

Parent/guardian signature if under 18:
In case of emergency, I hereby give permission for my child to be transported to the nearest hospital/emergency center for emergency medical treatment. Attempts to contact me will begin immediately.

Signature________________________________Date____________