



Medical Information Form

Name of child(first)_____ (last) _____

Birthdate ____/____/____

List any allergies, illness or disabilities of which we should be aware:_____

IN CASE OF ACCIDENT OR ILLNESS PLEASE LIST 3 CONTACTS THAT WILL BE AVAILABLE IN ADDITION TO PARENT.

PARENT TELEPHONE_(____)_____

PARENT NAMES_____

Parent cell_(____)_____

Relationship_____ Name_____

Telephone_(____)_____

Relationship_____ Name_____

Telephone_(____)_____

Relationship_____ Name_____

Telephone_(____)_____

Please provide Insurance Information should your child need medical attention.

I do not have medical insurance coverage for my child.

I do have medical insurance coverage for my child as follows:

Provider _____

Contract Number _____

Subscriber _____

Telephone Number for Insurance Co. _____

This form must be accompanied by notarized medical consent form.