

## EMERGENCY MEDICAL INFORMATION

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Medical/Hospitalization Insurance Provider: \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ ID Number: \_\_\_\_\_

Date of last Tetanus Shot: \_\_\_\_\_

Recommended Immunizations Current Based on Age? Yes \_\_\_\_\_ No \_\_\_\_\_

Regularly Used Medications: \_\_\_\_\_

\_\_\_\_\_

Activity Restrictions? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain here:

\_\_\_\_\_

\_\_\_\_\_

Other Comments Related to Child's Health:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date