Health information

Child's Name______________________________________ Birth date ______________

Child's home address_____________________________________City_____________Zip__________

Mother's Name____ Day Phone__________________

Father's Name________________________________ Day Phone ________________

EMERGENCY: If parents cannot be reached, contact:

Name____Phone____________________

Relationship ____

Physician______________________________ Office Phone______________________

Regular Medications____

Date of last physical exam____________________________________

Does this child have any specific health problems which the staff should be aware of? (e.g. vision or hearing lost, allergies, drug reactions, convulsions, etc.) **If "YES"**, please explain:

Special instructions in case of medical emergency:

Has your child had any serious illnesses, accidents, surgeries, or communicable diseases? If "YES" please explain____

Insurance Coverage (Company) ____

Group Number_______________________ Membership Number_______________________

CONSENT FOR MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

I,_______________________________ the parent/legal guardian _________________________, authorize and consent to medical, surgical, and hospital care, treatment, and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment.

Signature of Parent/Guardian______________________________ Date___________________