

Emergency and Medical Information Form

Child's Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Date of Birth: _____

E-Mail Address: _____

Mother's Name: _____

Mother's Work #: _____ Mother's Cell #: _____

Father's Name: _____

Father's Work #: _____ Father's Cell #: _____

Emergency Contact Person (Other than parent) _____

Relationship to Child _____

Phone Number _____ Cell # _____

Child's Pediatrician: _____

Pediatrician's Phone #: _____

Insurance Child is Carried Under: _____

Insurance Phone #: _____

Policy #: _____ Allergies: _____

Blood Type: _____ Race: _____

Height: _____ Weight: _____

Hair Color: _____ Eye Color: _____

Sex: _____ Birthmarks: _____

I give permission for my child (or legal ward) to be treated or attended to by authorized medical personnel in the event of an emergency. I, therefore, hold free from liability all attending medical personnel acting according to accustomed procedure and rendering general and special medical related treatment on behalf of and for the goodwill of my child (or legal ward).

Signature: _____