 East Cocalico Emergency Medical Information

NAME OF CHILD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOES YOUR CHILD HAVE ANY CHRONIC ILLNESS? \_\_\_\_\_YES \_\_\_\_\_NO IF YES, EXPLAIN

IS YOUR CHILD CURRENTLY ON ANY MEDICATION? \_\_\_\_\_YES \_\_\_\_\_ NO IF YES, EXPLAIN

DOES YOUR CHILD HAVE ANY ALLERGIES? \_\_\_\_\_ YES \_\_\_\_\_ NO IF YES, EXPLAIN

HAS YOUR CHILD HAD A TETANUS INJECTION? \_\_\_\_\_ YES \_\_\_\_\_ NO DATE OF LAST SHOT

IN CASE OF EMERGENCY ROOM CARE PLEASE PROVIDE THE FOLLOWING:

INSURANCE POLICY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF INSURANCE COMPANY OF THE INSURED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN CASE OF MEDICAL EMERGENCY, I UNDERSTAND EVERY EFFORT WILL BE MADE TO CONTACT PARENTS OR

GUARDIAN OF THE CHILD. IN THE EVENT I CANNOT BE REACHED, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED TO HOSPITALIZE, SECURE PROPER TREATMENT, AND TO ORDER INJECTION, ANESTHESIA OR SURGERY FOR MY CHILD AS NAMED ABOVE.

FAMILY PHYSICIAN NAME & ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY PHYSICIAN PHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE SIGNATURE OF PARENT OR LEGAL GUARDIAN

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (other than parent)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_