Emergency Medical Information

Full Name________________________	Doctor's Name____________________
Address__________________________	Address__________________________
City_____________________________	City_____________________________
State__________ Zip Code__________	State__________ Zip Code__________
Birthday__________ Age__________	Doctor's Office Ph#________________
Home Ph#________________________	Doctor's Home Ph#________________
Father's Work Ph#________________	Emergency Ph#____________________
Mother's Work Ph#________________	Emergency Ph#____________________
Insurance Company________________	Insurance Card#__________________
Agent___________________________	Policy#_________________________

Health History

Has he/she had:	Yes	No		Yes	No
Appendectomy	☐	☐	Sinus trouble	☐	☐
Asthma or hay fever	☐	☐	Fainting Spells	☐	☐
Hernia (rupture)	☐	☐	Ear trouble	☐	☐
Rheumatic fever	☐	☐	Poison ivy, oak, sumac	☐	☐
Diabetes	☐	☐	Convulsions	☐	☐
Does he/she take insulin?	☐	☐	Reaction to penicillin	☐	☐
Poliomyelitis	☐	☐	Nervousness or easily upset	☐	☐
Heart trouble	☐	☐	Allergy to aspirin	☐	☐
Severe allergies	☐	☐	Is he/she under medication?	☐	☐
Scarlet fever	☐	☐		☐	☐
Is His/her activity restricted due to medical reasons?				☐	☐

Date of last tetanus shot ____________________

If the answer is "yes" to any of the above, or if your child has any medical conditions or allergies not already listed please explain on the bottom of this form.