

## *Medical information*

Child's full name \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

School: \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Mother's wrk # \_\_\_\_\_ Father's wrk # \_\_\_\_\_

Mother's Cell # \_\_\_\_\_ Father's Cell # \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Please list TWO emergency contacts in case parents cannot be reached

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Physicians Name \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Co. & Policy Number \_\_\_\_\_

Any Physical limitations, allergies, or medications? \_\_\_\_\_

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Please note any additional details or concerns on the back of this form