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 _____