Emergency / Health Information

Child's Full Name: ______________________________

Date of birth: ____________ Age: _____ Nickname: ____________

In case of an emergency, please contact:

Name	Rlationship	Number	Other number

Address: ______________________________

Mother's name: ____________ Father's name: ____________

Lives with: ______________________________

Child's doctor: ____________________ Number: ____________

Address: ______________________________

Child's dentist: ____________________ Number: ____________

Address: ______________________________

Medical History

Are immunizations up to date? ________ (please provide documentation)

Does your child have any health concerns? ________________________________
____

Does your child take any medications on a regular basis? (if yes, please list name and dosage) ____
____
____

Does your child have any known allergies? (if yes, please list) _________________
____

Do you have any hearing or vision concerns with your child? __________________

Does your child experience any of the following on a regular basis?

Nosebleeds _____ Headaches _____ Stomachaches _____

Seasonal allergies _______ Other ____________________________________

Has your child had any surgeries? (if yes, please list) _______________________
____
____

Are there any other medical concerns we should be aware of? ________________
____
____
____