



Medical and Emergency Information

Name of Child: _____ Date of Birth: _____

Name Relationship to child Phone #

Name Relationship to child Phone #

Allergies (food, medicine, etc.): _____

Existing medical conditions: _____

Medications currently being taken: _____

Name of Physician: _____ Phone : _____

Persons who have permission to pick up child at the end of each session:

Name Relationship to child Phone #

Name Relationship to child Phone #

Signature of Parent or Guardian

Date

