Medical and Emergency Contact Form
(please fill out one form for each registrant.)

Child's General Information

Name: _____

Birthday: _____Age: _____

Doctor's Name: _____ Doctor's Phone #:_____

Does your child have developmental and/or physical challenges? (If yes, please explain)

_____

Doe your child have allergies?

Is your child taking any mediation? (if yes, please specify)

Parent/Guardian Information
Full Name(s):

_____

Street Name & Number: _____ City: _____

Postal Code: _____ Home Phone#: _____

Work Phone #: _____ Cell Phone#: _____

E-mail Address: _____

Emergency Contacts & Information
Primary Emergency Contact Name: _____ Phone #:_____

Secondary Emergency Contact Name: _____ Phone #_____

I give permission for my child_____ to be taken to the hospital in case of an emergency, and consent to emergency treatment until the time of my arrival at the hospital. I understand that every effort will be made to contact me in the event that such an emergency takes place.

_____ _____

Signature of Parent/Guardian **Date Signed**