MEDICAL EMERGENCY FORM
Child's name _______________________________ D.O.B. _________ Date _________
Address_________________________________________ Phone _________________

IMPORTANT INFORMATION:
1. Does your child take daily medication? Yes ___ No ___
   If yes, please explain:
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

2. Does your child have any drug, food, or insect allergies? Yes ___ No ___
   If yes, please explain:
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

3. Does your child suffer from _____asthma, _____diabetes, or _____epilepsy?
   Check all that apply.

4. Will your child be bringing any medication to practices or games? Yes ___ No ___
   If yes, please name the medication and explain its purpose:
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

5.  Has your child had a tetanus shot? Yes ___ No ___

6. Is there anything else pertinent regarding your child's health or physical
   condition? Is yes, please explain:
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

List two people to contact in case of an emergency:
Parent or guardian's name ___________________________ Home phone _____________
Address_________________________________________ Work phone _________________
Second person's name _______________________________ Home phone _____________
Address_________________________________________ Work phone _________________
Relationship to child

Family doctor ____________________________ Phone ____________
Family dentist ____________________________ Phone ____________
Health plan name ____________________________
Health plan ID# ____________________________

Parent or guardian's signature ____________________________
Date ____________