CHILD'S MEDICAL AND EMERGENCY INFORMATION

Child's Name: _____
Date of Birth:_____
Health Card Number: _____
Known Allergies: _____
Other Health Information:
_____
_____

Doctor's Name:_____
Address: _____
_____

Phone Number: _____

Emergency Contacts:

Parent 1
Name:_____
Address:_____
Home Phone:_____ Cell: _____
Place Of Work: _____ Phone: _____

Parent 2
Name:_____
Address:_____
Home Phone:_____ Cell: _____
Place Of Work: _____ Phone: _____

Emergency Contact
Name:_____
Address:_____
Home Phone:_____ Cell: _____
Place Of Work: _____ Phone: _____

Child May Be Released To:
1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

IMMUNIZATION RECORD

(Contact your local Ministry of Health for complete details before filling in this area.)

Immunizations are up to date: YES_____ NO_____

Has your child had:		Does your child suffer from:	
Measles	_____	Headaches	_____
German measles	_____	Ear aches	_____
Chicken pox	_____	Stomach aches	_____
Mumps	_____	Colds	_____
Whooping cough	_____	Flu	_____
Other	_____	Sore throat	_____
	_____	Other	_____

EMERGENCY MEDICAL TREATMENT CONSENT

EMERGENCY MEDICAL CARE

I hereby grant permission for_____ to secure the necessary emergency medical treatment needed by my son/daughter,

_____,

in the event that I cannot be reached to otherwise authorize the same.

I will also take responsibility for the cost of emergency transportation.

Date:_____

Parent signature:_____

Parent signature:_____