Name (Last, First)
Street/City/ZIP
DOB_____________________Height_____________________Weight_______________
Age ______________________Sex ________________________Blood Type_____________

Emergency Contacts:

Mother - Home Phone ______________________________Work Phone _______________________
Father - Home Phone ______________________________Work Phone _______________________
Other: Name ______________________________________Relationship _______________________
Home Phone ______________________________________Work Phone _______________________

MY CHILD HAS HAD:	YES	NO	MY CHILD HAS HAD:	YES	NO
Symptoms such as epilepsy, convulsion, loss of consciousness, dizziness, paralysis			Disease of the heart or blood vessels, increased or abnormal blood pressure		
Lung disease such as asthma, blood spitting, persistent cough			Arthritis, rheumatic fever, goiter, diabetes, kidney or bladder disease		
Stomach or intestinal trouble such as ulcers, gall bladder or liver disorder, jaundice, hernia			Pain in chest or shortness of breath		
			Hay fever or allergies		
Impaired sight or hearing, chronic ear infections			Any surgical operations, accidents or injuries		
Skin diseases			Allergies to medications		
Under care of physician			Other:		

Enter details for "Yes" answers on a separate sheet; indicate condition/diagnosis/date/hospital/length of stay/doctor/ and any other information helpful for emergency treatment