

## MEDICAL INFORMATION

Child's Name \_\_\_\_\_

### Medical Emergencies

**A.** In case of an emergency, when neither parent can be reached, give names of two people who will take responsibility for your child.

Name \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Relationship to child \_\_\_\_\_

Name \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Relationship to child \_\_\_\_\_

**B.** If parents cannot be reached and emergency medical advice is needed, permission is given to the Friendship Circle staff to phone my child's doctor.

Doctor \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_

Doctor's hospital affiliation \_\_\_\_\_

**C.** In case of medical emergency requiring immediate emergency care, I authorize the paramedics to take my child to the nearest hospital, if necessary.

Health insurance: Name \_\_\_\_\_ Number \_\_\_\_\_

### **D.** FURTHER MEDICAL INFORMATION

Allergic reactions to medication \_\_\_\_\_

Medication child is taking on a regular basis \_\_\_\_\_

Any special medical circumstances \_\_\_\_\_

### Administering prescription or Patent Medicine

I authorize the Friendship Circle staff to administer prescription or patent medicine to my child as specified in written instructions.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_