MEDICAL CARE AND EMERGENCY INFORMATION

CHILD'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PARENT/GUARDIAN NAME: _____ CELL: _____

PARENT/GUARDIAN NAME: _____ CELL: _____

ALTERNATE EMERGENCY CONTACT: _____ CELL: _____

CHILD'S PHYSICIAN: _____ PHONE: _____

CHILD'S DENTIST: _____ PHONE: _____

ANY KNOWN ALLERGIES (medicine, food, pollen, etc.): _____

_____

Describe any past serious conditions or illnesses which could affect your child's participation in the program's activities and any medical treatment necessary (diabetes, epilepsy, poor blood clotting, etc.):

_____

_____

EMERGENCY MEDICAL TREATMENT

In the event that I or my physician cannot be reached, I hereby authorize Chevy Chase Presbyterian Church After School Program to transport my child to the emergency room of the hospital(s) listed below, and I hereby grant my consent for the hospital and its medical staff to provide my child with emergency medical treatment which a physician deems necessary. If I have not specified any hospital below, my child may be taken to and cared for at the nearest hospital. I agree to accept financial responsibility for all medical expenses incurred.

HOSPITAL: _____ HOSPITAL: _____

HEALTH INSURANCE: _____

POLICY NUMBER: _____

PARENT/GUARDIAN PRINTED NAME: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____