MEDICAL FORM

Child's full name: ____ ☐ F ☐ M

Date of Birth: ______________________ Medicare: ______________________

Name of parent or legal guardian to contact in case of emergency: ______________________

Address: ____

Telephone numbers (please include all numbers where you can be reached) ______________________

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Name and relationship of another person to contact in case of an emergency: ______________________

Telephone: ____

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Name of Family Physician or Pediatrician: ______________________

Telephone: ____

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Does your child have any medical problems such as: Asthma, Epilepsy, Diabetes or other? ____________

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Any known allergies? ____

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Any medication: ____

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Comments: ____

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Parent or Guardian signature: ______________________ Date: ____________