



MEDICAL FORM

BASIC INFORMATION:

Child's Full Name _____

Date of Birth _____ Boy Girl

MEDICAL HISTORY:

Allergies: _____

Medical problems: _____

Any other relevant information which we need to be aware of: _____

EMERGENCY CONTACTS:

Name _____ Address _____

Phone Number _____ Relationship _____

Name _____ Address _____

Phone Number _____ Relationship _____

PHYSICIAN TO CALL IF CHILD BECOMES ILL OR INJURED:

Family Doctor Name _____

Address _____

Phone Number: _____

Parent/Guardian Signature

Date