TRIAD BAPTIST CHURCH CHILD ENRICHMENT CENTER

1175 South Main Street, Kernersville, NC 27284 (336) 996-7573

EMERGENCY MEDICAL INFORMATION

CHILD'S NAME: _____ BIRTHDATE: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

NAME OF PARENT/GUARDIAN: _____ PHONE: _____

PARENT/GUARDIAN EMPLOYER: _____ PHONE: _____

EMERGENCY CONTACTS IN THE EVENT THAT PARENTS CANNOT BE REACHED:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

HOSPITAL PREFERENCE: _____

HEALTH EXAMINATION BY LICENSED PHYSICIAN

Please answer the following questions.

1. Does the child have any physical condition of which we should be aware?

2. Does the child require special attention, medications or routines that ma be taken into consideration?

3. Explanation of any reported loss of consciousness, convulsion or concussion.

4. Any medically prescribed meal plan or dietary restrictions?

5. Any allergies?

6. Does child have epilepsy?

7. Does child have asthma?

In my opinion, the condition of the above named child [ ] DOES [ ] DOES NOT preclude his/her participation in an active schedule.
I have examined the above applicant within the last 2 years. DATE: _____

_____ PHONE: _____
LICENSED PHYSICIAN'S SIGNATURE

INSURANCE INFORMATION

Insurance provider: _____

Card holder: _____ Social Security Number: _____

Card holder's relationship to above named child: _____

Policy #: _____ Group #: _____

PLEASE ATTACH A CURRENT COPY OF CHILD'S IMMUNIZATION HISTORY