

**EMERGENCY MEDICAL INFORMATION
(Children Only)**

Students Name _____ Birth Date _____

Address _____ Home Phone _____

Mother's Name _____ Cell Phone _____

Father's Name _____ Cell Phone _____

IN CASE OF ILLNESS, PLEASE LIST NAMES AND TELEPHONE NUMBERS TO BE CALLED IN EMERGENCY IF PARENT
CANNOT BE REACHED

Name	Address	Phone
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Name	Address	Phone
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In the event of an emergency and I cannot be reached, I give my permission for my son/daughter to be given immediate medical care at a hospital or other medical/dental facility

Doctor's Name _____ **Phone** _____

Date _____ **Parent/Guardian** _____

TO BE COMPLETED BY PARENT:

Medical/Orthopedic/Emotional Conditions _____

Explain _____

Allergies _____

Medication taken daily _____

Other comments _____

Date of last physical _____

Signature of Parent/Guardian _____

_____ Date

THIS FORM MAY BE SHARED WITH THE INSTRUCTOR