MEDICAL EMERGENCY INFORMATION

Childs Name: ____

Child's DOB: ________________________ Current Weight: (for OTC meds) _____________________

Known Medical Conditions (for example, asthma, autism, hyperactivity, migraines) and Allergies (Drug, Food or Environmental):

____

____

Will your child be taking any prescribed medications (daily or as needed)? If yes, list medication:

____

Additional information/instructions: ____

In the event my child becomes ill or is injured, I authorize the registered nurse to administer over-the-counter medications, for example Ibuprofen, Acetaminophen, Benadryl and to give first aid.

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In the event of an EMERGENCY, the leader or nurse will call the parent/guardian at the contact number listed below.

CONTACT INFORMATION, NAME AND PHONE NUMBERS:

____

____

Medical Insurance Carrier and Policy #: ____

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Signature of Parent/Guardian Date