AFAN EMERGENCY CONTACT AND MEDICAL FORM

The information requested on this page is confidential and for emergency use only. In the event of an emergency, this information will be used by program staff and emergency personnel.

SECTION 1. BASIC CONTACT INFORMATION

Child's Last Name Child's First Name Child's Middle Name

Home Address:

City State Zip Code Date of Birth

Telephone 1: Telephone 2: Telephone 3:

IN CASE OF EMERGENCY, CONTACT:

1.

Name Relationship

Street Address City State Zip Code

Telephone 1: Telephone 2: Telephone 3:

2.

Name Relationship

Street Address City State Zip Code

Telephone 1: Telephone 2: Telephone 3:

CHILD'S PHYSICIAN

Name Phone

CHILD'S DENTIST/ORTHODONTIST

Name Phone

Name Phone

SECTION 2. INSURANCE INFORMATION

Insurance Carrier: Group or Policy #:

Address for Claims:

Policy Holder's Name: _____ Relationship to Child: _____

Policy Holder's Date of Birth: _____ Policy Holder's Insurance ID #: _____

SECTION 3. HEALTH INFORMATION

1. Does the child currently have any of the following? (If yes, please list or describe.)

a. Drug allergies:

b. Allergies to insect bites:

c. Food allergies:

d. Special dietary needs:

e. Asthma:

f. Dizziness or seizures:

g. Activity limitations or restrictions:

h. Other health problems:

2. Please list any medications that the child is currently taking:

3. Date of last medical check-up:

My child, _____, has permission to engage in all program activities except as noted above. The information provided on this form is accurate to the best of my knowledge, and I have indicated any special health conditions that should be known to program staff and medical personnel. In the event of an illness or injury when I am not present to give consent, I hereby give permission to medical personnel selected by the acting program director to order x-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby grant permission to medical personnel to secure and administer emergency medical treatment, including hospitalization, for my child.

Signature of Parent/Guardian: _____ Date: _____

I give permission to the program staff to transport my child to and from program activities. I also agree that any of my emergency contacts listed on this form may be notified in an emergency, as needed.

Signature of Parent/Guardian: _____ Date: _____