EMERGENCY MEDICAL INFORMATION

CHILD'S NAME_____ DATE OF BIRTH _____

ADDRESS_____ HOME PHONE _____

FATHER'S OR GUARDIAN'S PHONE AT

WORK_____

MOTHER'S OR GUARDIAN'S PHONE AT WORK _____

PEDIATRICIAN'S NAME_____ PHONE/OFC._____H_____

FAMILY DOCTOR'S NAME_____ PHONE/OFC._____H_____

ALTERNATE DOCTOR'S NAME_____ PHONE/OFC._____H_____

DENTIST NAME _____ PHONE/ OFC._____ H_____

MEDICAL INSURANCE COMPANY NAME_____

ADDRESS_____ POLICY NUMBER_____

ARE IMMUNIZATIONS UP TO DATE? _____YES _____NO

BLOOD TYPE_____ RH FACTOR: (*Check One*) RH NEGATIVE _____RH POSITIVE_____

PRESENT MEDICAL PROBLEMS & CHRONIC CONDITIONS (EPILEPSY, ASTHMA, ETC.)

_____

_____

_____

MEDICINES TAKEN REGULARLY

NAME_____ REASON TAKEN_____ DOSE & FREQUENCY_____

NAME_____ REASON TAKEN_____ DOSE & FREQUENCY_____

NAME_____ REASON TAKEN_____ DOSE & FREQUENCY_____

WILL SHE NEED TO TAKE MEDICATION AT GIRLS INC.? _____YES _____NO

SPECIAL PRECAUTIONS & OTHER INFORMATION

_____

_____

_____

I/We, the undersigned parents or guardians of _____ a minor, hereby authorize Girls Inc. staff to sign for and authorize admission and treatment of the above named minor for any emergency medical procedure deemed necessary by the medical staff. I also authorize the physician and medical staff to perform any emergency procedure necessary, and realize that such treatment, not covered by Girls Inc. insurance will be at my/our expense. I have read and thoroughly understand all of the above.

_____ _____

Signature of Parents or Legal Guardian **Date**