



MEDICAL INFORMATION

Student Name: _____ **Date of Birth:** _____

Emergency Contact

Name: _____ Relationship to Student: _____

Home Phone: _____ Work/Cell/Other Phone: _____

Address: _____

Parent Email Address: _____

Medical Information

Physician's Name: _____ Physician's Phone: _____

Physician's Address: _____

Medical Insurance: _____ Policy Number: _____

Other Medical Information

Is your child currently on any medication? If yes, please list the type(s) of medication and specific instructions for each: _____

Can any first aid and/or non-prescription medication be administered to your child? If no, please list exceptions: _____

Does your child have any allergies? If yes, please list allergies including any reactions to medication: _____

Does your child have any activity and/or dietary restrictions? If yes, please list any restrictions: _____

Is there any additional medical information (including medical conditions) regarding your child that the nurse/adult leader should be aware of? If yes, please list the information: _____

Can your child be given Tylenol, Aspirin, and/or motion sickness medication? If no, please list which medication(s) your child may not be given: _____