Kids' Corner After School Program
Health and Emergency Form

CHILD_____ DATE OF BIRTH_____
HOME ADDRESS_____ HOME PHONE_____
SCHOOL _____ GRADE_____

EMERGENCY CONTACTS

1) _____
(Parent/Guardian #1) (Cell Phone)

_____
(Home Address) (Home Phone)

_____
(Employer & Town) (Work Phone)

2) _____
(Parent/Guardian #2) (Cell Phone)

_____
(Home Address) (Home Phone)

_____
(Employer & Town) (Work Phone)

3) _____
(Other) (Phone) (Relationship)

4) _____
(Other) (Phone) (Relationship)

(Side A)

CHILD _____

MEDICAL INFORMATION

Physician: _____ Phone: _____
Address: _____
Medical Insurance: _____ Plan #: _____
Date of Latest Tetanus Immunization: _____

ALLERGIES (CHECK THOSE APPLICABLE OR SPECIFY TYPE)

Penicillin Reaction _____ Food Allergies _____
Bee Sting Reaction _____ _____
Asthma _____ _____
Other _____

SPECIAL HEALTH CONCERNS or MEDICAL CONDITIONS:

I/WE hereby confirm that my/our child has been examined by a physician within the last two years and that there are no apparent reasons for her/his not participating in routine physical activities.

And give permission for my/our child to be transported to the local hospital for immediate attention if deemed necessary by the program staff and that, in case of injury or illness, emergency medical care may be administered in the event that one of the contacts designated above cannot be reached promptly.

SIGNATURE _____ DATE _____

SIGNATURE _____ DATE _____

(Side B)