

Medical Form

Family Last Name: _____

Child First Name	DOB	Doctor's Name	Doctor's Phone #	Medical Conditions/ Allergies	Medication
1.					
2.					
3.					
4.					
5.					

Emergency Contact

Emergency Contact		Phone Number	
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Insurance Information

Insurance Company		Name of Policy Holder	
Policy Number		Group Number	

PLEASE ACCEPT THIS LETTER AS AUTHORITY TO TREAT, IN CASE OF EMERGENCY, MY CHILD OR CHILDREN WHOSE NAMES ARE LISTED ABOVE.

Signature _____

Date _____