MEDICAL/EMERGENCY INFORMATION

NAME: _____

SOCIAL SECURITY NUMBER: _____ **DOB:** _____

IDENTIFYING MARKS (Scars, Birthmarks, Tattoos, etc): _____

Primary nationality	Gender	Height	Weight	Hair Color	Eye Color

ALLERGIES: (FOOD, MEDICATION, ETC.):

_____

MEDICAL HISTORY (HEALTH ISSUES):

_____

MEDICATION:

_____

PARENT/GUARDIAN:

NAME: _____ **PHONE:** _____

NAME: _____ **PHONE:** _____

EMERGENCY CONTACT:

NAME: _____ **PHONE:** _____

NAME: _____ **PHONE:** _____

Emergency Contact is Authorized to pick up and transport: _____ **YES** _____ **NO**
(21 years of age or older with ID)

I hereby acknowledge and verify that the information I provided above is correct and answered to the best of my knowledge.

Parent/Guardians Name: _____ Signature: _____ Date: _____

"THIS INSITUTION IS AN EQUAL OPPORTUNITY PROVIDER"