

**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 INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER”