UVJC Emergency Contact and Medical Information for a Child

***** Fill out one for each Child *****

Child's Name

Date of Birth

M F
Sex

Parent's/Guardian's Name

Home Phone

Work Phone

Address

City, ST ZIP Code

Parent's/Guardian's Name

Home Phone

Work Phone

Address

City, ST ZIP Code

Alternative Emergency Contacts

Primary Emergency Contact

Home Phone

Work Phone

Address

City, ST ZIP Code

Secondary Emergency Contact

Home Phone

Work Phone

Address

City, ST ZIP Code

Medical Information

Hospital/Clinic Preference

Physician's Name

Phone Number

Insurance Company

Policy Number

Allergies/Special Health Considerations

I authorize the UVJC to administer medications that I have supplied for medical conditions noted above. I have supplied the following medications to the Director of Education, and instructions are attached to the medications supplied.

_____ _____

Parent's/Guardian's Signature

Date