CARES
Medical Form

Child's Name: ________________________________ DOB: ________________

Allergies: ____

Other Medical Conditions that CARES staff should be aware of? _____________

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Physician Name: ___________________________ Phone:____________________

Address: ____

Dentist Name: _____________________________ Phone: ____________________

Address: ____

In case of an accident or serious illness, I request CARES to contact me. If the staff is unable to reach me, I hereby authorize the CARES staff to call the physician or dentist indicated above and follow his/her instructions. If it is impossible to contact this physician or dentist, CARES may make emergency arrangements.

Parent/Guardian Signature: ____

Printed Name: ____

Date: ____________________________