ST BASIL THE GREAT CATHOLIC YOUTH ORGANIZATION

EMERGENCY INFORMATION

CHILD'S NAME
DATE OF BIRTH
ADDRESS HOME PHONE
MOTHER'S WORK PHONE CELL PHONE
FATHER'S WORK PHONE CELL PHONE
INSURANCE COVERAGE GROUP/IDNUMBER
PERSON TO CONTACT IN CASE OF EMERGENCY NAME/RELATIONSHIP
PHONE NUMBER
FAMILY DOCTOR PHONE
DATE OF LAST TETNUS TOXOID INJECTION
DOES CHILD WEAR CONTACT LENSES? YES NO
LIST ALL KNOWN ALLERGIES
MEDICATION YOUR CHILD CAN NOT TAKE
MEDICATION YOUR CHILD IS PRESENTLY ON
DOES YOUR CHILD HAVE ANY OF THE FOLLOWING: HEART CONDITION: YES NO
ASTHMA: YES NO EPILEPSY: YES NO DIABETES: YES NO
EAR OR NOSE CONDITION: YES NO
DOES YOUR CHILD HAVE ANY OTHER HEALTH CONCERNS? YES NO IF YES, PLEASE EXPLAIN
COMMENTS FROM PARENTS:
IN THE EVENT OF AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE ST BASIL THE GREAT CATHOLIC YOUTH ORGANIZATION AND STAFF TO SECURE PROPER EMERGENCY TREATMENT FROM A LICENSED PHYSICIAN OR TO FACILITATE TRANSPORTATION OF MY CHILD TO THE NEAREST HOSPITAL FOR EMERGENCY TREATMENT, AND/OR TO HOSPITAL ONLY.
PARENT SIGNATURE DATE