

**CHILD'S EMERGENCY MEDICAL INFORMATION:**

Child's Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Medical facility the Center uses: \_\_\_\_\_

Address: \_\_\_\_\_

Does your child have allergies or other physical problems, mental health disorder, mental retardation or developmental disabilities, which would limit the child's participation in the Center's program and activities?

Yes       No      If yes, specify: \_\_\_\_\_

Does your child have allergies (insects, medications, food, etc.)?  Yes    No

If yes, specify: \_\_\_\_\_

Are there any special procedures required in caring for your child?  Yes    No

If yes, specify: \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date