

MEDICAL HISTORY & INFORMATION

NAME OF CHILD _____

PRESENT MEDICATIONS, SCHEDULE AND DOSAGE _____

DO CPQM STAFF NEED TO OVERSEE TAKING OF MEDICATION? _____

OTHER INFORMATION _____

MEDICAL HISTORY/CONCERNS

DATE OF LAST TETANUS SHOT _____

ALLERGIES _____

FAMILY DOCTOR _____ PHONE _____

INSURANCE COMPANY _____

POLICY HOLDER'S NAME _____ POLICY NO. _____

IF AN HMO, PLEASE GIVE PHONE NO. _____

CHILD'S SOCIAL SECURITY NUMBER _____

PARENTS'/GUARDIANS' EMERGENCY NUMBERS DURING PROGRAM

Mother's/legal guardian's name _____ Day phone _____ Eve phone _____

Father's/legal guardian's name _____ Day phone _____ Eve phone _____

IN THE EVENT THAT THE PARENT CAN NOT BE CONTACTED, PLEASE CALL:

Name _____ Relationship _____

Day phone _____ Eve phone _____

PLEASE ASK YOUR SON OR DAUGHTER TO CARRY HIS OR HER
INSURANCE CARD OR A PHOTOCOPY OF IT TO THE WEEKEND

(One form required for each and every child. Please copy if necessary.) Please complete with full details, in ink.