

EMERGENCY MEDICAL INFORMATION (Mail in)
BROOKLINE SUMMER SCHOOL 2017

Student: _____ **Date of Birth:** _____

Grade entering in Sept: _____ School: _____

Address: _____ Home phone: _____

Parent/Guardian: _____ Work or Cell phone: _____

Parent/Guardian: _____ Work or Cell phone: _____

Pediatrician's Name: _____ Phone: _____

Emergency contact if parent/guardian is not available:

Name: _____ Relationship to student: _____

Address: _____ Phone: _____

Health Information

Does your child have an allergy to **food, bee stings, or insects**? ___ yes ___ no

If yes, what is the allergen?

Does your child use an Epi-Pen? ___ yes ___ no Treatment?

Does your child have any **other allergies** (aspirin, etc.)? ___ yes ___ no

If yes, what is the allergen?

Treatment?

Does your child have any medical concerns? ___ yes ___ no

If yes, please state the diagnosis:

Does your child take medications? ___ yes ___ no

If yes, please list the medications:

Are there any factors that make it advisable for your child to follow a program of limited physical activities?

___ yes ___ no If yes, please specify the limitations:

Health Insurance Provider: _____ Subscriber: _____ Policy # _____

We will contact parents/guardians in case of serious illness or accident. However, in the event of an emergency situation that requires immediate medical attention I, _____, hereby give permission to the physician selected by the Director or the Trip Leader to hospitalize, secure proper treatment for, order injection, anesthesia, or surgery for my child as named above.

Signed: _____ **Relationship to child** _____

Date: _____

