

ArtsROC Emergency Contact & Medical Information Form

_____		_____		M F
Child's Name		Date of Birth		Sex
_____		_____		
Mother/guardian's Name		Father/guardian's Name		
_____		_____		
Cell Phone	Alternate Phone	Cell Phone	Alternate Phone	
_____		_____		
Address		Address		
_____		_____		
City, Street, Zip		City, Street, Zip		

Alternate Emergency Contacts

_____		_____	
Primary Emergency Contact/Relationship		Secondary Emergency Contact/Relationship	
_____		_____	
Cell Phone	Alternate Phone	Cell Phone	Alternate Phone
_____		_____	
Address		Address	
_____		_____	
City, Street, Zip		City, Street, Zip	

Medical Information

Hospital/Client Reference	

Physician's Name	Phone Number

Insurance Company	Policy Number

Existing Medical Conditions/Current Medications	

Allergies & Special Needs (diet, physical restrictions/limitations, etc.)	

I have attached a record of my child's immunization history

Agreements

I consent to the enrollment of my child in programs at ArtsROC and have been advised of the policies regarding administration of medication, fees, transportation, and the services provided by the facility. In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advised by the physician, surgeon, or hospital (listed above) necessary for the proper health and well-being of my child. Y or N

I have provided information on my child's special needs (allergies, diet, disabilities, and/or medical information) to ArtsROC as may be necessary to assist them in properly caring for the well-being of my child. Y or N

I agree to review and update this information whenever a change occurs. Y or N

_____	_____
Signature of parent/guardian	Date

