Dover Township Parks and Recreation

Confidential Emergency Medical Information

Please Print Clearly!

Child Name:_____ Birth Date:_____

Day Phone#- _____ Evening Phone #: _____

Home Address: _____

Street City/State Zip Code

Name and Address of Physician or source of medical care: _____

_____

Phone #- _____------_____

List all allergies (include any known allergic reactions to medications): _____

_____

List medications and dosages that you take on a regular basis:_____

_____

Contact Lenses worn? Yes ____ No _____ Glasses Worn? Yes _____ No _____

Existing Medical Condition(s):_____

Physical Disability (if any):_____

Hospital Preference: _____

Last Serious illness: _____ Date:_____

Reason for hospitalization: _____Date: _____

Health insurance: Primary Carrier:_____ Secondary Carrier_____

List two people to be contacted in case of emergency:

1. Name_____ Daytime Phone # _____

Daytime Location/ Address _____ Relationship_____

Evening Phone # _____ Release child to this person? Yes _____ No _____

2. Name_____ Daytime Phone # _____

Daytime Location/ Address _____ Relationship_____

Evening Phone # _____ Release child to this person? Yes _____ No _____

I give my consent for the Dover Township Recreation Department to obtain emergency medical care for my child(ren) if needed and I authorize the release of this medical information to emergency medical personnel.

_____ _____

Parent/Guardian Signature Date