Medical Information Form

Child's Name ____

Health Insurance Carrier ______________________________ Group or ID #_________________

Name of Subscriber __________________________ Relationship to Child ___________________

Child's Social Security Number ____

Does the child have any allergies (hay fever, food, insect bites, medication)? _____________________

____

Does the child have any health condition(s) which may impact the child's activities or health care (i.e. asthma, seizure, insect sting, allergy, bleeding, diabetes, heart problems)? _______________________

____

Is the child on medication at home? ____

Do you authorize the employees of Hiking Along to administer first aid (bandages, antibacterial cream, splints, CPR, etc.) in case of an accident or emergency?

_____YES _____NO

Emergency Contact Information

Name ____
(another name besides the one printed above)

Daytime Address ____

Daytime Telephone Number ____

Relationship ____

Parent Signature _____________________________________ Date ________________