

**Kids' Corner After School Program  
Health and Emergency Form**



CHILD \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

**EMERGENCY CONTACTS**

1) \_\_\_\_\_ (Parent/Guardian #1) \_\_\_\_\_ (Cell Phone) \_\_\_\_\_  
\_\_\_\_\_ (Home Address) \_\_\_\_\_ (Home Phone) \_\_\_\_\_  
\_\_\_\_\_ (Employer & Town) \_\_\_\_\_ (Work Phone) \_\_\_\_\_

2) \_\_\_\_\_ (Parent/Guardian #2) \_\_\_\_\_ (Cell Phone) \_\_\_\_\_  
\_\_\_\_\_ (Home Address) \_\_\_\_\_ (Home Phone) \_\_\_\_\_  
\_\_\_\_\_ (Employer & Town) \_\_\_\_\_ (Work Phone) \_\_\_\_\_

3) \_\_\_\_\_ (Other) \_\_\_\_\_ (Phone) \_\_\_\_\_ (Relationship) \_\_\_\_\_

4) \_\_\_\_\_ (Other) \_\_\_\_\_ (Phone) \_\_\_\_\_ (Relationship) \_\_\_\_\_

(Side A)

CHILD \_\_\_\_\_

**MEDICAL INFORMATION**

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Medical Insurance: \_\_\_\_\_ Plan #: \_\_\_\_\_  
Date of Latest Tetanus Immunization: \_\_\_\_\_

**ALLERGIES (CHECK THOSE APPLICABLE OR SPECIFY TYPE)**

Penicillin Reaction \_\_\_\_\_ Food Allergies \_\_\_\_\_  
Bee Sting Reaction \_\_\_\_\_  
Asthma \_\_\_\_\_  
Other \_\_\_\_\_

**SPECIAL HEALTH CONCERNS or MEDICAL CONDITIONS:**

I/WE hereby confirm that my/our child has been examined by a physician within the last two years and that there are no apparent reasons for her/his not participating in routine physical activities.

And give permission for my/our child to be transported to the local hospital for immediate attention if deemed necessary by the program staff and that, in case of injury or illness, emergency medical care may be administered in the event that one of the contacts designated above cannot be reached promptly.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

(Side B)