CENTRAL BAPTIST CHURCH

1505 West Street • Southington, CT 06489
(860) 621-6701

EMERGENCY MEDICAL INFORMATION

Student's Name_____ Home Phone # (_____)_____

Date of Birth_____ Age _____ Sex _____ Social Security #_____

Address_____

Please list any allergies your child has had: _____

Please list any diseases your child has had: _____

Please check if your child is subject to:

☐ Asthma ☐ Earache ☐ Hay Fever ☐ Bronchitis ☐ Other _____

Medications your child takes regularly: _____

☐ Epi-Pen ☐ Inhaler (Asthma) ☐ Diabetes ☐ Heart Condition ☐ Bleeding Disorders

In case of an emergency requiring medical care outside of the school, please indicate the sequence in which you would like us to contact you.

- ☐ Contact father: Phone #_____
- ☐ Contact mother: Phone #_____
- ☐ Contact personal physician: Name_____ Phone # :(_____)_____
- ☐ Take child to nearest hospital
- ☐ Take child to_____ Hospital City: _____
- ☐ Other Procedure: _____

Insurance Company _____

Policy Holder _____ Policy Number _____

Employer of policy holder _____ Work Phone _____

Address of employer _____

Has student had any head injuries? ☐ Yes ☐No How many _____ When_____

Has anyone in your family died suddenly before age 60? ☐ Yes ☐ No Explain _____

_____

I give permission for _____to participate in _____ all sports/_____all sports except _____. I assume all responsibility for notifying the school of any change in my child's health both before and during participation in any sport(s). I hereby give permission for the provision of emergency medical treatment for my child in the even to injury or illness that occurs during participation in school sponsored activities.

In case of surgical emergency, I hereby give permission to the physician selected by the Central Baptist Church staff to hospitalize, secure proper treatment, and order injection, anesthesia or surgery for my child.

Parent's Signatures:

_____ _____ _____

Father Mother Date