



HEALTH INFORMATION: (For use in case of emergencies while participating in church functions)

Please provide health insurance information (insurance company(s), plan number(s), member name):

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Please list primary physicians and/or health care providers and their phone numbers for each child.

Child	Physician	Phone
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Do any of these children take prescription drug(s) or medication regularly? No: \_\_\_\_\_ Yes: \_\_\_\_\_  
If yes, who and what? \_\_\_\_\_

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Do any of these children have allergies? No: \_\_\_\_\_ Yes: \_\_\_\_\_

If yes,	Child's name	Allergy **
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	<hr/>	<hr/>
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\*\*Please indicate which, if any, may result in a reaction requiring immediate or emergency attention and provide any additional necessary information in the space provided at the end of this form.

**Please add any additional information that you feel should be included with your family's record.**