

MEDICAL INFORMATION

Allergies _____

Medication and Treatment _____

Medical Conditions _____

Medication and Treatments _____

Health Insurance Company (US) _____ Policy # _____

Name of Emergency Contact _____ Emergency Contact # _____

Parent/Guardian's Signature: _____ Name: _____ Date: _____
(Please Print)

Child's Signature: _____ Name: _____ Date: _____
(Please Print)

Full Child's Name: _____ Sex _____ Grade _____ Email _____

Address: _____ City _____ State _____ Zip _____

Telephone (_____) _____ Vegetarian meals required: Yes _____ No _____ Other _____