

2006-07 CHB Learning Zone -- Medical Form

If medical treatment becomes necessary to preserve the health of my child(ren) while under the care of CHB's Learning Zone, I authorize any member of the Learning Zone Committee (Jody Gibbs, Nancy Boland, Beth Taylor, or Mary Bellamy) to seek appropriate medical treatment. I understand that I am responsible for paying for treatment obtained on my child(ren)'s behalf.

Signature: _____ Date: _____

Family Medical Info *(attach additional sheets if necessary for space)*

Family Physician:		Phone:	
Insurance Carrier:	Policy:	Group:	
Parents Names:			
Address:			
Home Phone:		Cell:	
Work Phone:		Spouse's Cell:	
Emergency Contact Info (who we should contact if no one can be reached using the above info. Include home and cell numbers):			

Individual Children's Medical Info *(attach additional sheets if necessary for space)*

Child's Name:		Birth Date:	
Allergies:			
Current Medications:			
Child's Name:		Birth Date:	
Allergies:			
Current Medications:			
Child's Name:		Birth Date:	
Allergies:			
Current Medications:			
Child's Name:		Birth Date:	
Allergies:			
Current Medications:			
Child's Name:		Birth Date:	
Allergies:			
Current Medications:			