2009-2010 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 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:	

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Allergies:	
Current Medications:	

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