EMERGENCY I.D.

Paste Photo Here

Name: _____
Add: _____
City, State: _____
Birthdate: _____
MEDICAL INSURANCE INFORMATION:
Carrier: _____
Policy #: _____
Pol. Holder: _____

IN CASE OF EMERGENCY CONTACT:
Name: _____ Phone: _____
Name: _____ Phone: _____
Physician: _____ Phone: _____

MEDICAL RELEASE - In the event of accident, injury, or illness, and if reasonable efforts to contact me have failed, I hereby give attending physicians or authorized medical personnel consent and permission provide _____ with any necessary medical treatment, including X-rays and medication.

_____
Signature parent or Legal Guardian Date

BRIEF MEDICAL HISTORY (including medical allergies and other important information):

_____
_____
_____

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