

# Health Form

Child's Name \_\_\_\_\_  
Last Name First Name

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone Father ( ) \_\_\_\_\_

Cell Phone Mother ( ) \_\_\_\_\_

Physician to be called in an emergency \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Dentist to be called in emergency \_\_\_\_\_

Phone ( ) \_\_\_\_\_

**Please indicate any known allergies:**

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In the event that our child becomes ill in school and we are unavailable, we hereby authorize the following individuals to transport and care for our child.

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_