

Important Information

Child's Name: _____

Date of Birth: _____

Parent/Guardian Names: _____

Home Telephone: _____

Work Telephones: _____

Address: _____

Important Health Problems/Allergies: _____

Medications Taken Regularly: _____

Doctor Names and Phone Numbers: _____

Dentist's Name and Phone Number: _____

Health Insurance Numbers: _____

Pharmacy Names and Phone Numbers: _____

Poison Control Center Number: _____
