

EMERGENCY FORM

Parent or Guardian --- Please complete the following information (printing clearly)
HAND IN TO COACH THE FIRST DAY YOUR CHILD PRACTICES.

CHILD/FAMILY INFORMATION

Child's Name _____ Nickname _____
Male ____ Female ____ Birthdate _____ Age ____ Grade (as of 9/1/07) _____
Home Address _____ Zipcode _____
Home Phone _____ Languages Spoken at Home _____

In case of emergency, which parent/guardian should we contact first? Mother ____ Father ____
Mother/Guardian Name _____ Father/Guardian Name _____
Address _____ Address _____
Home Phone _____ Home Phone _____
Work Phone _____ Work Phone _____
Place of employment _____ Place of employment _____
e-mail address _____ e-mail address _____

EMERGENCY INFORMATION

*If my child requires emergency medical care and I cannot be reached, I give my consent to the YMCA Staff to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives.
In case of emergency, and the YMCA staff are unable to reach the parent/guardian listed above, the following individuals have permission to make decisions regarding the care of my child.*

Name _____ Name _____
Relationship to child _____ Relationship to child _____
Home Phone _____ Work Phone _____ Home Phone _____ Work Phone _____
Home Address _____ Home Address _____

HEALTH INFORMATION *(Indicate "yes" where it applies and explain as necessary).*

Health			Allergies		
Asthma _____	Convulsions _____	Emotional/	Hay Fever _____		
Diabetes _____	Hearing _____	Psychological _____	Poison Ivy _____		
Special Diet _____	Vision _____	Learning Disabilities _____	Insect _____		
Physical _____	Illness _____	ADD/ADHD _____	Medication _____		
Restraints _____	Injury _____	Operations _____	Food _____		
Other _____			Other _____		

Please explain details of above "yes" answers.

Is your child currently taking prescribed or over-the-counter medication? Yes ____ No ____

Is your child covered by any hospitalization/medical care policy? Yes ____ No ____

Insurance Company _____

Policy Holder's Name _____

Policy Holder's Date of Birth _____

Policy # (include all letters and numbers) _____

Does your child have a doctor? Yes ____ No ____

Name of Physician _____ Phone _____

Does your child have a dentist? Yes ____ No ____

Name of Dentist _____ Phone _____

Any other health/medical information we should know? _____

Child Profile (Optional)

The following information will help us to better understand your child and his/her needs.

1. Are there any known speech, hearing, or vision difficulties? _____

 2. Are there any medical problems that require special attention or of which we should be aware? _____

 3. Does your child display any emotional fears, behavior problems, or difficulties in dealing with others? _____

 4. What techniques of discipline do you find most effective? _____

 5. Does your child receive any special services through school? _____

 6. If you could describe your child in one phrase, what would it be? _____

 7. Who does the child live with and what is their relationship to him/her? _____

 8. Why do you want your child in this program? _____

 9. Activities to be encouraged: _____
 10. Activities your child cannot participate in: _____
 11. Is there anything else we should know about your child? _____

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