PHYSICIAN/MEDICAL INFORMATION

Physician/Clinic: ______________________________________ Phone: ____________

Address: ____

Insurance Carrier: ___________________________Insurance #__________________

Special instructions when calling:____

I authorize "Little Halos" to call my child's pediatrician to discuss my child's health when I am not available by phone.

Parent/Guardian Signature: _______________________________ Date: ____________

HEALTH INFORMATION

Allergies (food, medication, insects, animals, seasonal):________________________

____

Regular Medications: ____

Chronic Illness: ____

Special Needs: ____

____

I hereby authorize "Little Halos" to administer rudimentary First Aid and/or CPR to my child when necessary. I also authorize "Little Halos" to call 911 to transport my child by ambulance, when I cannot be reached or when delay would be dangerous to my child's health, to the following hospital of my choice__________________________________ (if appropriate) or to where EMT's determine best.

Parent/Guardian Signature: ________________________________ Date: ___________