CATHARINE STREET COMMUNITY CENTER

MEDICAL INFORMATION

Please answer these questions to the best of your knowledge.

Does your child have any of the following?

Asthma _____ Prone to nosebleeds _____
Seizures _____ Prone to fainting_____
Allergies*_____
*(Please specify what kinds of allergies, including bee stings**
_____
****We must have a doctor's note for any food allergies****
Is your child presently taking medication? Yes_____ No _____

If yes, please list medication here _____

Is a special diet required for your child? Yes_____ No _____
If yes, please specify diet and condition: _____

Child's Physician _____ Phone Number _____

Address_____

Dentist _____ Phone Number_____

Address_____

Does your child have medical coverage (insurance)? _____
If yes, name and type of insurance_____

In case of an emergency, which hospital should your child be taken to?
Vassar Brother's Hospital_____ Westchester Medical Center_____

Are there any special recommendations concerning your child's health? Yes___ No ___
If yes, please specify: _____

MEDICAL TREATMENT CONSENT

I, _____ , hereby authorize the Catharine Street Community Center to consent to emergency medical treatment for my child (under the advice of a New York State licensed physician or surgeon, and/or the child's own doctor) when the need for such treatment is immediate and when efforts to contact me are unsuccessful.

Signature: _____ **Date**: _____

Additional Persons Approved for Pick-UP (CSCC will not release your child into the custody of another individual unless you name that person below as authorized)**:**

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____