

CASP Emergency Medical Information Sheet
2011-2012

Child's Name: _____

Name of Doctor: _____

Address of Doctor: _____
Street Address City

Doctor Phone: (____) _____

Medical Insurance Carrier: _____

Policy No: _____

Name of Dentist: _____

Address of Dentist: _____
Street Address City

Dentist Phone: (____) _____

Dental Insurance Carrier: _____

Policy No: _____

Preferred Hospital: _____
Name City

Hospital Phone: (____) _____

Is your child allergic to any medications? If yes, please specify:

In the event of a medical/dental emergency . . . If we cannot reach a parent, is there anyone else you would like us to call?

Name: _____ Relationship to child: _____

phone: (____) _____ / (____) _____

Parent Name (print neatly) Parent Signature Date
