CASP Emergency Medical Information Sheet

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
