

McKEEVER ENVIRONMENTAL LEARNING CENTER

HEALTH INFORMATION FORM

(TO BE USED BY McKEEVER STAFF AND MEDICAL PERSONNEL ONLY)

Name: _____ Date of Birth: _____ Phone #(____)

Permanent Address:

In case of accident, please notify:

Name: _____ Relation: _____ Phone # (____)

Address:

If above person cannot be reached, please contact:

Name: _____ Relation: _____ Phone # (____)

Address:

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Please state in detail any medical condition of which we should be aware: () None (Check if not applicable)

In case of emergency, may we have your permission to call a doctor and have him/her attend, treat and give medications, by mouth or injection, including toxoids or antibiotics? () yes () no

May we have your permission to transport you to UPMC in Greenville or Grove City for medical treatment if necessary? () yes () no

Insurance Coverage:

Insurance Company:

Card Holder's Name: _____ Insurance or Group # _____

Signature: _____ Date: