Medical Information Form

Physician (optional):

Youth Insured:____DOB:____________________

Physician:____________________________________ Phone:_________________________________

Address:____

____

Medical Insurance (optional):

Insurance Company: ____

Identification Number: ____

Group Number: ____

Insured's Name: ____

Please check any of the following that apply to your child:

______Allergic to peanuts

______Allergic to grass

______Allergic to bees

______Asthma

______Allergic to dairy

______Diabetic

______Vegetarian

______Does not eat pork

______Other food allergies: _______________________

Please list any other allergies:

____

____

____

List of medications:

No medication will be given to any youth unless listed below. (This includes Tylenol, Aspirin, etc)
If you give permission for your child to take over the counter medication, please list it below and provide the medicine.

Name of medicine:_______________________________ Dosage:_____________________________

Other instructions:____

Name of medicine:_______________________________ Dosage:_____________________________

Other instructions:____

Name of medicine:_______________________________ Dosage:_____________________________

Other instructions:____

Please list any other special conditions that we should be aware of:

____

____

____

____

____

____

____

____

In case of an emergency, would you prefer your child to go to Children's Hospital, Providence Hospital or Washington Hospital Center? ____

Do you give your permission for your child to ride in an ambulance to the hospital in an emergency situation? Please circle YES or NO

(Dance Place reserves the right to call 911 and an ambulance if this is a life threatening situation)

Additional Information:

____

____

____

____

____

____

Parent/Guardian Signature: X____ Date: __________________

3225 8th St. NE 20017 • 202.269.1600 • 2 blocks from CUA/Brookland Metro