# EMERGENCY INFORMATION

NAME: _____

ADDRESS: _____

NAME OF DOCTOR: _____ PHONE:

_____

HOSPITAL PREFERENCE: _____ PHONE: _____

LIST ANY CHRONIC MEDICAL CONDITIONS, INCLUDING MEDICATIONS TAKEN FOR THAT CONDITION, WHICH WOULD BE RELEVANT IN AN EMERGENCY SITUATION: _____

_____

_____

EMERGENCY CONTACT PERSONS:

NAME: _____ RELATIONSHIP:

_____

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE: _____

NAME: _____ RELATIONSHIP:

_____

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE: _____

# HEALTH QUESTIONNAIRE

***IMPORTANT*** — Current health information must be completed annually by all volunteers prior to their coming into contact with the children.

NAME: _____

HOME ADDRESS: _____

TELEPHONE NUMBER: _____

I certify that I am emotionally and physically fit to care for children.

Signature: _____ Date: _____