



Miracles and Memories Academy

Emergency Medical Information

PARTICIPANTS NAME		BIRTHDATE
ADDRESS		TELEPHONE NUMBER
PARENT/GUARDIAN NAME	TELEPHONE NUMBER	CELL PHONE NUMBER
PARENT/GUARDIAN ADDRESS		
GUARDIAN EMAIL		
EMERGENCY CONTACT #1	TELEPHONE NUMBER	RELATIONSHIP
EMERGENCY CONTACT #2	TELEPHONE NUMBER	RELATIONSHIP

MEDICAL INFORMATION

DIAGNOSIS, CHRONIC OR EXISTING MEDICAL OR DEVELOPMENTAL CONDITIONS (Asthma , Seizures, Diabetes, Risk for Aspiration, etc.)	
KNOWN ALLERGIES/REACTIONS (Medications, Food, Environmental, Insects/Animals)	
OTHER CONCERNS	
PRIMARY PHYSICIAN	TELEPHONE NUMBER

Emergency Medical Consent

In the event of a medical emergency and a parent/guardian cannot be reached I _____ (parent/guardian) give consent for _____ to receive necessary emergency medical treatment.	
PARENT/GUARDIAN SIGNATURE	DATE