Registration Form

Child's Name/Age _____/____ _____/____ _____/____ Birth date ___/___/_____

Home Address _____ City _____ Zip _____

Child's Soc. Sec. No. *_____ Family Doctor _____ Phone No. _____

* Social Security Number is optional, some hospitals WILL NOT treat without it.

Allergies/Chronic Conditions (e.g. epilepsy, diabetes)/Medications _____

Other information we should know about your child _____

Parent or Guardian Contact No. (c) _____ (h) _____(w) _____

Emergency Contact _____ Phone No. (c) _____ (h) _____

Medical Insurance Co._____ Policy No. _____

Member's Name _____ Phone No. (h) _____ (w) _____

Member's Birth date ____/____/_____ Member's Soc. Sec. No. * _____