MEDICAL INFORMATION FORM

By filling out this form, I acknowledge that I give CHE volunteers permission to seek medical treatment for my child(ren) in case of an emergency. I recognize that CHE, CHE volunteers, and the host location will not assume financial responsibility for any injury, accident, or medical care received.

Children's Name(s): _____

_____

Parents' Name(s): _____

Address: _____

City, State, Zip: _____

Phone: _____ Cell Phone(s): _____

Persons (other than parents) to Notify in case of emergency (with phone numbers)

_____

_____

Allergy/ Medical Information:

_____

_____

_____

_____

_____

Any other information you would like us to know about your children:

_____

_____

_____

_____

_____