



Youth Builder Program

Sponsored by Youth and Families Enrichment Services

HEALTH / OFFICE EMERGENCY

Please fill in the following information and return it to Youth builder Program. This information is important in case of illness, emergency, or unscheduled dismissal from program. This information will be kept confidential and shall only be used by BMC to provide necessary, immediate treatment for your child.

STUDENT NAME _____ DATE OF BIRTH _____

ADDRESS _____ ZIP CODE _____

MOTHER'S NAME _____ HOME TEL _____

MOTHER'S EMPLOYER _____ WORK TEL _____

FATHER'S NAME _____ HOME TEL _____

FATHER'S EMPLOYER _____ WORK TEL _____

In the event that parent cannot be reached in an emergency or in the case of illness please list two responsible adults to contact.

NAME _____

ADDRESS _____ TEL # _____

NAME _____

ADDRESS _____ TEL. # _____

PRIMARY LANGUAGE SPOKEN AT HOME _____

ARE THERE ANY CUSTODY ISSUES OF WHICH WE SHOULD BE AWARE? IF SO,

EXPLAIN: _____

(PLEASE CONTINUE ON NEXT PAGE)

If emergency medical attention is necessary and we cannot reach you, do you authorize staff to initiate medical treatment (please check one) YES ___ NO ___?

HOSPITAL/HEALTH CENTER WHERE YOU TAKE YOUR CHILD IF HE/SHE IS ILL

NAME _____
ADDRESS _____ TEL _____

DOES CHILD HAVE ANY HEALTH PROBLEM OF WHICH WE SHOULD BE AWARE? PLEASE STATE BELOW

DOES CHILD HAVE A CHRONIC DISEASE SUCH AS:

Check all that apply:

Asthma Diabetes Seizure Sickle cell anemia
 Others? (Please specify) _____

DOES CHILD TAKE:

Insulin Metformin Albuterol inhaler Medications for pain
 Seizure medication Others (Please specify) _____

ALLERGIES:

FOOD _____

MEDICATION _____

DOES CHILD HAVE ANY DISABILITY THAT REQUIRES SPECIAL NEEDS OR SEAT

ARRANGEMENT? (PLEASE CHECK ONE) YES ___ NO ___

IF YES, SPECIFY _____

IS THERE ANY ADDITIONAL INFORMATION OF WHICH WE SHOULD BE AWARE?

Parent's Signature

Date