TEAM DIXON MEDICAL EMERGENCY FORM

Child's Name: _____DOB_____

Parent/ Guardian Name:_____ Ph: _____

Home Address:_____

Alternate/ Emergency Contact Name:_____ Ph:_____

** Information contained within this document will be kept confidential and held by Team Dixon administration or authorized personnel.

CHILD'S MEDICAL PROVIDER/ HOSPITAL:

Physician Name:_____Ph:_____

Physician Address_____

Hospital: _____

CHILD'S MEDICAL INFORMATION:

Please list all current medical conditions, disabilities, and any other information related to your child's physical and mental health.

_____

_____

_____

_____

MEDICATIONS: Please list all medications being taken by your child, and dosage:

_____

_____

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