



Operation New Life - Chapel Hill, NC

MEDICAL FORM

Child's Full Name: _____

Child's Date of Birth: _____ S.S. # _____

Parent's or Guardian's Full Name(s): _____

Address: _____

Home Phone: _____ Work: _____ Emergency: _____

Permission

In the case of an emergency, I, _____ give my permission for the ONL staff members or volunteers to administer medication to my child or take my child, _____ to the hospital or elsewhere for immediate medical attention if needed.

Name of preferred physician: _____

Address: _____ Phone: _____

Preferred hospital: _____

Insurance Policy: Company _____ # _____

Medical Information

1. Does your child have any medical problems? Yes _____ No _____

If yes, describe _____

2. Does your child have any allergies? Yes _____ No _____

If so, what is your child allergic to? _____

3. Is your child currently taking any medication? Yes _____ No _____

If yes, list medications: _____

4. Are there any activities (running, jumping, swimming) that your child should not do because of his or her health? Yes _____ No _____

If yes, describe: _____

Emergency Contact:

Name: _____ Relationship: _____

Home Phone: _____ Cell/Alternate: _____