SAGAN *Life* ®

IDENTIFICATION

Name _____ DOB _____ _____ _____ Male / Female _____
FIRST   MIDDLE INITIAL   LAST   M   D   Y

Home Address _____ City _____ State _____ Zip Code _____

Phone Home _____ Work _____ Cell _____ Email _____

Height _____ Weight _____ Eye Color _____ Blood Type / RH Factor _____ Identifying Marks _____

KEY INFORMATION FOR EMERGENCY MEDICAL PERSONNEL

Key Information for Emergency Medical Personnel:
_____
_____

Child's Medical History:
_____
_____

Special Needs:
_____
_____

Child's Personality:
_____
_____

What Calms My Child Down:
_____
_____

EMERGENCY CONTACTS

Parent/Guardian 1 Name _____ Relationship _____
FIRST   LAST

Phone Home _____ Work _____ Cell _____ Email _____

Parent/Guardian 2 Name _____ Relationship _____
FIRST   LAST

Phone Home _____ Work _____ Cell _____ Email _____

Local Contact 1 Name _____ Relationship _____
FIRST   LAST

Phone Home _____ Work _____ Cell _____ Email _____

Local Contact 2 Name _____ Relationship _____
FIRST   LAST

Phone Home _____ Work _____ Cell _____ Email _____

Out-Of-Town Contact Name _____ Relationship _____
FIRST   LAST

Phone Home _____ Work _____ Cell _____ Email _____

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EMERGENCY CONTACTS (CONTINUED)

School Name _____ Address _____
STREET   CITY   STATE   ZIP

Phone _____ Teacher _____ Teacher Email _____

After School Program Name _____ Address _____
STREET   CITY   STATE   ZIP

Phone _____ Supervisor Name _____

Daycare Provider Name _____ Address _____
STREET   CITY   STATE   ZIP

Phone _____ Supervisor Name _____

Babysitter Name _____ Phone _____

PHYSICIANS

Primary Physician _____ Specialty _____
FIRST   LAST

Phone _____ Hospital Affiliation _____

Dentist _____ Phone _____
FIRST   LAST

MEDICATIONS

Pharmacy _____ Location _____ Phone _____
STREET   CITY   STATE   ZIP

Prescription Medication

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

ALTERNATIVE MEDICATIONS/SUPPLEMENTS

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

Name _____ Dosage _____ Frequency _____ For What Condition _____

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ALLERGIES AND CHRONIC CONDITIONS

Allergy Type _____ Severity _____ Frequency/Last Occurance _____

Notes _____

Allergy Type _____ Severity _____ Frequency/Last Occurance _____

Notes _____

Chronic Condition _____ Severity _____ Current Treatment _____

Chronic Condition _____ Severity _____ Current Treatment _____

HEALTH INSURANCE

Health Insurance Company _____ Member Number _____

Policy Number _____ Group Number _____

Hospital Of Choice _____ Agent Name _____ Agent Number _____

NOTES

Other Additional Information: