SAGAN Life®

Child Medical Emergency Form

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:

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