



## MEDICAL INFORMATION

1. List medical/hospital insurance carrier \_\_\_\_\_

2. Name of your child's physician \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Do you want your doctor called in case of an emergency if you are unable to be reached?

Yes \_\_\_\_\_ No \_\_\_\_\_

3. List any allergies your child may have:

4. List any known problems your child has:

5. List any medications given on a regular basis:

6. Immunization Data: (List Month/Year) - (See Required Immunization List)

Hep B      1st \_\_\_\_\_      2nd \_\_\_\_\_      3rd \_\_\_\_\_

DTaP      1st \_\_\_\_\_      2nd \_\_\_\_\_      3rd \_\_\_\_\_      4th \_\_\_\_\_      5th \_\_\_\_\_

OPV/IPV      1st \_\_\_\_\_      2nd \_\_\_\_\_      3rd \_\_\_\_\_      4th \_\_\_\_\_

HIB      1st \_\_\_\_\_      2nd \_\_\_\_\_      3rd \_\_\_\_\_      4th \_\_\_\_\_

MMR      1st \_\_\_\_\_      2nd \_\_\_\_\_

Chicken Pox 1st \_\_\_\_\_

I hereby give consent for emergency treatment and hospitalization for the child below if I am not available to give consent at the time of need. In my absence the Grove City United Community Hospital or other appropriate hospital is authorized to perform and arrange for any necessary treatment and hospitalization that is required including the obtaining of physician specialist, in the absence of the physician listed above, that may be necessary for treatment.

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

Child's Name \_\_\_\_\_

NOTE: Every effort will be made to contact the parents or other persons indicated on page 1.

**Please mail completed application and deposit to:**

Grove City College Education Department

C/O Carolyn Patterson

100 Campus Drive # 3031

Grove City, PA 16127