Medical Emergency Form

Child's Name ____

Mother/Guardian's Name ____

Home Phone __________________________ Cell Phone __________________________

E-mail Address: ____

Father/Guardian's Name____

Home Phone __________________________ Cell Phone __________________________

E-mail Address: ____

My insurance provider is ____

Preferred hospital/treatment center ____

My child is taking the following medications

__________________________ _______________________ _______________________

My child has the following allergies or medical precautions

__________________________ _______________________ _______________________

I understand the Boston Ability Center will contact 911 in case of a medical emergency. I assume all financial responsibility in case of a medical emergency, medical injury including transportation.

____ __________________

Name of Parent or Guardian Date

____ __________________

Signature of Parent or Guardian Date