Medical Alert Information

Childs Name: _____ Date of Birth: _____

1. List any chronic medical conditions your child has: (i.e. asthma, seizures, ear infections, etc.)

2. List all allergies, type of reaction these allergies cause, and is an EpiPen needed:

3. List all medications with dosages and reason child takes it: (please inform us if there are any changes)

4. List all medications child is allergic to:

Children At Play Early Intervention Center
40 Merrill Avenue Staten Island, NY 10314
Phone: 718.370.7529 • Fax: 718.370.7551 • respite@childrenatplay.org

5. In the event of an emergency and we cannot contact you or the emergency contact please advise how you would like CAP to proceed:

6. Name, phone number, and address of Child's Physician:

7. Preferred hospital:

In the event of an emergency or in case of an injury, I _____ authorize Children At Play to act on my behalf to obtain medical treatment for my child, including calling 911 and instructing the ambulance to go to the local hospital or your preferred hospital.

_____ _____

Parent/Guardian Signature Date

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