THE CENTER FOR CREATIVE LEARNING
Insurance and Health Information Card

_____ _____
Last name of minor First name Birth date

_____ _____
Address of minor (with city, state and zip, please!) phone number

The undersigned hereby authorize any adult representative of The Center for Creative Learning and consent to any X-Ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the MEDICAL PRACTICE ACT, or any dentist licensed under the provisions of the DENTAL PRACTICE ACT.

Type of medication and specific instructions:_____
_____
Allergies, including reactions to medications: _____
_____
Activity Restrictions:_____
_____
Additional information that adult representatives should be aware of:_____
_____

_____ _____
signature of Father or Guardian signature of Mother or Guardian

_____ _____ _____
Today's Date Insurance Carrier policy number

<u>Emergency Contact Information:</u>

Father: _____ Mother: _____
Address _____ Address _____
Employer: _____
Cell Phone: _____ Cell Phone: _____
Home Phone: _____ Home Phone: _____
E-Mail Address_____ E-Mail Address _____

In case of emergency, who can we contact if you are not available?

Name: _____ Relationship: _____ Phone:_____
Name: _____ Relationship: _____ Phone:_____