

**Health Form (One Per Child)**

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

**MEDICAL EMERGENCY CONTACT INFORMATION**

Person to contact first: \_\_\_\_\_ Backup contact (relative or friend): \_\_\_\_\_  
Name \_\_\_\_\_ Name \_\_\_\_\_  
Relation \_\_\_\_\_ Relation \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Alternate Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

**PARTICIPANT'S DOCTOR INFORMATION**

Doctor's Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

**INSURANCE POLICY INFORMATION**

The above-named child is covered by health insurance: Yes No  
Policy Holder's (PH) Name \_\_\_\_\_ Relation \_\_\_\_\_  
P.H.'s Employer \_\_\_\_\_ Insurance Company \_\_\_\_\_  
Policy # \_\_\_\_\_ Plan# \_\_\_\_\_

**Please check and comment if there has been a history of the following:**

Asthma       Hyperactivity       Heart trouble       Convulsions/Seizures       Trouble with ears  
 Hives       Chronic cough       Shortness of breath       Frequent headaches       Hay fever  
 Bleeding disorder       Diet restrictions       Food allergies       Severe allergic reactions       Trouble with eyes  
 Other (please explain) \_\_\_\_\_

**Unusual sensitivity to:**

Insect/Bee stings       Poison Oak/Ivy       Sunburn/Sunscreen  
 Other (please explain) \_\_\_\_\_

**Please comment on all checked items (use extra sheet if needed):**

\_\_\_\_\_

Is your child on any medication that is taken at home?  Yes  No (JEI staff are not able to dispense prescribed medications.)  
Name of Medication/Reason \_\_\_\_\_

**CONSENT to Treatment of a Minor**

The undersigned, as parent or legal guardian of \_\_\_\_\_ (participant's name, please print clearly), hereby authorizes the JEI Learning Center of Marlboro and its staff to consent to any medical and hospital care to be rendered to said minor upon advice of a licensed physician. The undersigned further agrees that the JEI Learning Center and its staff are not legally or financially liable for any claim arising from any consent given in good faith in connection with such diagnosis or advised treatment. This authorization and consent to treat of a minor is given to JEI Learning Center and shall remain effective during the entire period the said minor is enrolled.

\_\_\_\_\_  
Parent's/Guardian's Name (Please print)      Signature of Parent/Guardian      Date