Personal Information Form

Fall 20__ - Spring 20__

Name: _____

Address: _____

_____

_____

Phone: _____

E-mail: _____

Emergency Medical Release Authorization

I hereby give permission for any necessary medical attention to be administered to any child listed below in the event of an accident, injury, sickness etc. that might occur during any Lighthouse activity until such a time as I may be contacted. I also assume responsibility for payment of such treatment.

Please Note: If you have any questions regarding the legal implications in signing this form, please be certain to consult with an attorney prior to signing.

_____ _____

Signature **Date**

Child's Name:	Child's Name:
Age: Grade: DOB:	Age: Grade: DOB:
Primary Care Physician:	Primary Care Physician:
Physician's Phone:	Physician's Phone:
Insurance Policy #:	Insurance Policy #:
Allergies:	Allergies:

Child's Name:	Child's Name:
Age: Grade: DOB:	Age: Grade: DOB:
Primary Care Physician:	Primary Care Physician:
Physician's Phone:	Physician's Phone:
Insurance Policy #:	Insurance Policy #:
Allergies:	Allergies: