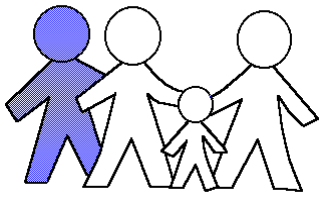

DR. ANGELA FOUNTAIN, C. Psych. & Associates
1037 Howden Rd. E., Oshawa, Ontario L1H 7K4
Tel: (905) 655-5813
www.drfountain.ca

Children's Emergency and Medical Information

Child's Name: _____Sex: Male____ Female_____
Last *First* *MI*

Address:_____
Street *City* *Province* *Postal code*

Phone (h):_____ Child's Date of Birth / /

1. Parent/Guardian Name: _____
Last *First* *MI*

E-Mail_____

Address:_____
Street (if different from child's) *City* *Province* *Postal code*

Phone (h)_____
(w)_____
(c)_____

2. Parent/Guardian Name:_____
Last *First* *MI*

E-Mail_____

Address:_____
Street (if different from child's) *City* *Province* *Postal code*

Phone (h)_____
(w)_____
(c)_____

Parents/Guardians Place of Employment: father_____
mother_____

**Mandatory 2 Emergency Contacts other than parents

Emergency Contact #1_____Relationship to Child_____

Address_____

Phone (H)_____ (W)_____

Emergency Contact #2_____Relationship to Child_____

Address_____

Phone (H)_____ (W)_____

Child's Physician (name & phone)_____

OHIP #:_____

Please Check Yes or No

___Yes ___No Is your child under physician's care or taking medications on a continuing basis? If yes, please explain what for. _____

_____

___Yes ___No Does your child have any allergies? If yes, please specify allergies._____

What should be done if your child comes into contact with an allergen?_____

___Yes ___No Does your child have any chronic problems, special needs, or other conditions we should know about that you have not already discussed on intake? If yes, please explain

_____

___Yes ___No Does your child take medications? If yes, please list. If during camp, you must fill out proper medical authorization forms

_____

___Yes ___No I give permission for pictures & videos of my child to be used in promotional advertising for programs run at Dr. Angela Fountain & Associates

How did you hear about the Summer Youth & Kids Club? (circle one)

Dr Fountain's office School Resources for Exceptional Children

Other Doctor:_____ Other:_____

I hereby authorize Dr. Angela Fountain & Associates to seek medical treatment for my child, at the nearest facility, in the event medical care is required. In the event non-emergency medical care is required, I authorize Dr. Angela Fountain & Associates to seek medical treatment through my child's physician. I understand that I am responsible for medical expenses incurred by my child. I have read Dr Fountain's Clubhouse procedure/policies form for the program and agree to adhere to them, including the policy if my child becomes ill, I must pick up my child immediately. I certify that the above information is complete and correct.

_____ _____

Parent/Guardian's Signature *Date*