BOWEN AFTER SCHOOL PROGRAM, INC
280 CYPRESS STREET, NEWTON, MA 02459, 617-969-3130
HEALTH HISTORY & EMERGENCY MEDICAL CARE CONSENT FORM
EMERGENCY CARD

Teacher's Name: _____ **Date of Birth**: _____

MEDICAL INFORMATION

Health Insurance Coverage: _____

Policy #: _____

Teacher's Physician: _____ Teacher's Dentist: _____

Street: _____ Street: _____

City: _____ State: ____ Zip: _____ City: _____ State: ____ Zip: _____

Phone #: _____ Phone #: _____

Medication taken regularly: _____

Teacher's allergies: _____

Chronic Health Conditions: _____

CONTACT INFORMATION

Emergency Contacts: People to contact in in the event of an emergency.

1.) Name: _____ Relationship: _____ Phone: _____

Street: _____ City: _____ State: _____ Zip: _____

2.) Name: _____ Relationship: _____ Phone: _____

Street: _____ City: _____ State: _____ Zip: _____

3.) Name: _____ Relationship: _____ Phone: _____

Street: _____ City: _____ State: _____ Zip: _____

MEDICAL TREATMENT/EMERGENCY TRANSPORTATION AUTHORIZATION

In the event of an emergency, I give permission to the Bowen After School Care Program, Inc. to provide first aid and, if necessary, to arrange for emergency transport to the most appropriate medical facility/hospital and to authorize emergency medical care by the hospital or local emergency medical care service.

➢ _____ _____

Signature Date

*******CONSENT INCLUSION DATES RUN FROM DATE OF SIGNATURE THROUGH JUNE 30, 2024***