TRURO HOMES ASSOCIATION	**EMERGENCY CARE INFORMATION** In case of an emergency, the pool staff will contact 911 Every attempt will be made to contact a parent or a designated emergency contact.	TRURO COMMUNITY CENTER

CHILD'S NAME

Last _____ Date of Birth _____

First _____ Sex ☑ Male ☐ Female ☐

Middle _____

Child resides with ☑ ☐ FATHER ☐ MOTHER ☐ LEGAL GUARDIAN

FATHER Language _____	ADDRESS	TELEPHONE
Last _____	_____	Home( ) _____
First _____	_____	Work ( ) _____
Middle _____	_____	Cell/Pager ( ) _____
MOTHER Language _____	ADDRESS	TELEPHONE
Last _____	_____	Home( ) _____
First _____	_____	Work ( ) _____
Middle _____	_____	Cell/Pager ( ) _____
LEGAL GUARDIAN-Language _____	ADDRESS	TELEPHONE
Last _____	_____	Home( ) _____
First _____	_____	Work ( ) _____
Middle _____	_____	Cell/Pager ( ) _____

LIST 2 PERSONS WE SHOULD CALL IN AN EMERGENCY IF THE PARENT(S)/GUARDIAN CANNOT BE REACHED

Name of Person	Relationship	Language	Telephone
1. _____			( ) _____
2. _____			( ) _____

PHYSICIAN INFORMATION

Medical Care is provided by _____ ( ) _____
(Name of doctor,clinic/HMO, etc.)

Medical Care is covered by _____ ( ) _____
(Health Insurance company, assistance program, HMO, etc.)

HEALTH INFORMATION

Check ☑ any current health condition that may require attention.

☐ Allergies (be specific)
- ☐ Foods _____
- ☐ Medicines _____
- ☐ Beesting/insect _____
- ☐ Other _____

☐ asthma
☐ cancer
☐ diabetes
☐ hearing problems ☐ hearing aid
☐ heart problems (be specific)_____
List all medication received on a continual basis:

☐ hemophilia
☐ physical disability (be specific)
_____
☐ respiratory (be specific)
_____
☐ seizures
☐ vision problems (be specific) _____
- ☐ glasses ☐ contacts

☐ other (be specific) _____
_____

Representatives of the Truro Homes Association or its swimming pool contractor have my permission, in an emergency when I (or my physician) cannot be contacted, to take my child to the emergency room of the nearest hospital, and the hospital and its medical staff have my authorization to provide treatment which a physician deems necessary for the well-being of my child.

PARENT/GUARDIAN SIGNATURE_____ **DATE:**_____