

CHEB Medical Form

If medical treatment becomes necessary to preserve the health of my child(ren) while under the care of CHEB, I authorize any member of the Board (Elizabeth Lin, Gladie Green, Cindy Crissman, Nikole Christensen, Tiffany Parsons) to seek appropriate medical treatment. I understand that I am responsible for paying for treatment obtained on my child(ren)'s behalf.

Signature: _____ Date: _____

Family Medical Info (attach additional sheets if necessary for space)

Family Physician:		Phone:	
Insurance Carrier:	Policy:	Group:	
Parents Names:			
Address:			
Home Phone:		Cell:	
Work Phone:		Spouse's Cell:	
Emergency Contact Info (who we should contact if no one can be reached using the above info. Include home and cell numbers):			

Individual Children's Medical Info (attach additional sheets if necessary for space)

Child's Name:	Birth Date:
Allergies:	
Current Medications:	

Child's Name:	Birth Date:
Allergies:	
Current Medications:	

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Allergies:	
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