2020-2021 Last Name _____

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 (Cindy Crissman, Elizabeth Lin, Christy Newman, Sarah Russell, Melissa Kramer, Karla Hiser, Nikole Christensen, and 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:	

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

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

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