SNOW CUBS - AGES 8 WEEKS to 3 YEARS
MEDICAL INFORMATION FORM

This form needs to be completed if a child is to be enrolled for more than 30 days. THIS FORM MUST BE SIGNED BY A PHYSICIAN. Forms may be faxed to our office at 970-923-0420 or emailed to: aporcaro@aspensnowmass.com or returned to our front desk.

Child's Name: ______________________________ Birth Date: ____________

Address: ____________________ City:____________ State: ___ Zip: ________

Home phone: ____________________ Cell phone: ______________________

Emergency contact other than parents:________________ Phone:____________

Physician Name: __________________________ Phone: ________________

Dentist Name__________________________ Phone:________________

Health Insurance Company:____________________ Policy #:______________

I give permission to my child's medical provider to complete this information and return it directly to Snow Cubs via fax or email.

Parent's Signature:__________________________ Date:______________

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MEDICAL PROVIDER - PLEASE COMPLETE THE BRIEF MEDICAL HISTORY BELOW.

Allergies:____

Surgery, Accidents, Illnesses, Chronic or Handicapping Problems: __________________

____

Describe any physical or emotional condition requiring special attention by staff:__________

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Medication prescribed:____

Other Concerns: ____

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*Please record immunizations and dates administered on a Colorado Department of Health Certificate and attach to this form.

Physician/ Practical Nurse Signature: __________________________ Date: ______

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