

# MILFORD COMMUNITY SCHOOL USE PROGRAM

Phone (508) 478-1119 • Fax (508) 634-2341

## Medical Information Questionnaire

NAME:	DATE OF BIRTH:
GRADE COMPLETED JUNE 2017:	AGE:
STREET:	MALE                  FEMALE
TOWN:	

PARENT/GUARDIAN NAME:
PHONE(S):
PARENT/GUARDIAN NAME:
PHONE(S):
OTHER EMERGENCY CONTACT NAME:
OTHER EMERGENCY CONTACT PHONE(S):

**Does your child have any medical concerns?**

Asthma \_\_\_\_\_ Seizures \_\_\_\_\_ Diabetes \_\_\_\_\_ Cardiac \_\_\_\_\_ Other \_\_\_\_\_

**Does your child have any allergies?**

Food \_\_\_\_\_ Bees \_\_\_\_\_ Medications \_\_\_\_\_ Other \_\_\_\_\_

**Does your child have an EpiPen/AuviQ?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Does your child take any medications? Please list:**

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**If your child needs medication during camp hours, please submit a MEDICATION FORM.**

**Please use this area to provide more details if necessary**

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