



## Medical Registration Form

Name of child	Date of Birth	Parent/Guardian Name	Phone Number
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### CHILD'S MEDICAL INSURANCE COVERAGE

Insurance company \_\_\_\_\_ Member/Policy Number \_\_\_\_\_

Policy holder name \_\_\_\_\_ Employer Name \_\_\_\_\_

### PROVIDER INFORMATION

Date of child's last physical \_\_\_\_\_ Date of last dental exam \_\_\_\_\_

Child's physician \_\_\_\_\_ Name of practice \_\_\_\_\_

Provider address \_\_\_\_\_ Phone \_\_\_\_\_

Child's dentist \_\_\_\_\_ Phone \_\_\_\_\_

### CHILD'S HEALTH INFORMATION

Current medications \_\_\_\_\_

Describe hearing, vision, or speech issues \_\_\_\_\_

Any food, medication, or environmental allergies? \_\_\_\_\_

Any medical, physical, or mental/behavioral conditions? \_\_\_\_\_

### CONSENT TO FIRST AID AND MEDICAL CARE AND TREATMENT OF A MINOR

I give permission for my child \_\_\_\_\_ to be given first aid by employees of Discovery Playtown. In the event of an emergency as determined by staff, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or emergency medical technician when deemed necessary or advisable to safeguard my child's health. I waive my right of informed consent to such treatment. I also give my permission for my child to be transported by ambulance to a medical facility for treatment. I agree to be responsible for all costs incurred and agree to hold the employees and owners of Discovery Playtown harmless for all liability and costs. I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent or guardian name (Print) \_\_\_\_\_

Parent or guardian signature	Date
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