GALAXY **EMERGENCY CONTACT FAMILY**

Family Last Name (s): **Family Contact Person:**

Parent #1 Name: **DOB:** **Cell:** **Other Number:** **Address**:	**Parent #1 Allergies/ Medical Concerns:** ☐ **Yes** ☐ **No** **Parent #1 Allergies/ Medical Concerns:** ☐ **Yes** ☐ **No**
Parent# 2 Name: **DOB:** **Cell:** **Other Number:** **Address**:	**Dependent Children Allergies/ Medical Concerns:**
Dependent Children: If medical concerns, please see page 3 1) **Name:** **DOB:** 2) **Name:** **DOB:** 3) **Name:** **DOB:** 4) **Name:** **DOB:** 5) **Name:** **DOB:**	1) ☐ **Yes** ☐ **No** 2) ☐ **Yes** ☐ **No** 3) ☐ **Yes** ☐ **No** 4) ☐ **Yes** ☐ **No** 5) ☐ **Yes** ☐ **No**
Physician Name: **Physician Phone Number**: **Physician Address**: **Preferred Hospital**: **Hospital Address**:	**Living Arrangement:** ☐ Parents live together ☐ Separated/ divorced

Emergency Contact #1 Information

Name: **Relationship to individual**:

Address:

Cell: **Work**: **Home**:

Emergency Contact #2 Information

Name: **Relationship to individual**:

Address:

Cell: **Work**: **Home**:

Medical Insurance Information/plan type: .
Policy Number:
Group Number:
Insurance Plan Provided Through Name: DOB:

Please fill out page 2 if anyone in the family has medical concerns we need to know about

SIGNATURE: ***DATE:*** ***RELATIONSHIP:***

GALAXY EMERGENCY ACTION PLAN

Please fill out this form if you have medical concerns we need to know about: EACH FAMILY MEMBER WITH ALLERGIES OR MEDICAL CONCERNS WILL NEED THEIR OWN ACTION PLAN

Name: **Age:**
Allergies: **Action:**

Allergy	Give Benadryl	Give Epi Pen	Prior Hospitalization	Symptoms if exposed
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Please Describe in further detail any MEDICAL CONCERNS we need to know about:

Please list any SPECIAL ACCOMMODATIONS you may need:

SIGNATURE: ***DATE:*** ***RELATIONSHIP TO INDIVIDUAL:***

Name: **Age:**
Allergies: **Action:**

Allergy	Give Benadryl	Give Epi Pen	Prior Hospitalization	Symptoms if exposed
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Please Describe in further detail any MEDICAL CONCERNS we need to know about:

Please list any SPECIAL ACCOMMODATIONS you may need:

SIGNATURE: ***DATE:*** ***RELATIONSHIP TO INDIVIDUAL:***

***If Galaxy staff feel it is necessary to call 911 we will do so even if another plan is indicated on this form.**