

Child/Adolescent Contact Information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

Date: _____
Date of Birth: _____
Gender: M F Age: _____

Insurance Information

Health Insurance Company: _____ Subscriber Name: _____
ID number: _____ Group/Policy #: _____

Contact Phone Numbers

Please complete relevant information and check boxes of custodial parents or legal guardians.

OK to leave messages?

<input type="checkbox"/> Mother's Name _____	
Home Phone () _____	<input type="checkbox"/>
Work Phone () _____	<input type="checkbox"/>
Cell Phone () _____	<input type="checkbox"/>
<input type="checkbox"/> Father's Name _____	
Home Phone () _____	<input type="checkbox"/>
Work Phone () _____	<input type="checkbox"/>
Cell Phone () _____	<input type="checkbox"/>
<input type="checkbox"/> Step-Mother's Name _____	
Home Phone () _____	<input type="checkbox"/>
Work Phone () _____	<input type="checkbox"/>
Cell Phone () _____	<input type="checkbox"/>
<input type="checkbox"/> Step-Father's Name _____	
Home Phone () _____	<input type="checkbox"/>
Work Phone () _____	<input type="checkbox"/>
Cell Phone () _____	<input type="checkbox"/>
<input type="checkbox"/> Legal Guardian's Name _____	
Home Phone () _____	<input type="checkbox"/>
Work Phone () _____	<input type="checkbox"/>
Cell Phone () _____	<input type="checkbox"/>
<input type="checkbox"/> Youth contact information (if different than above)	
Home Phone () _____	<input type="checkbox"/>
Work Phone () _____	<input type="checkbox"/>
Cell Phone () _____	<input type="checkbox"/>

Emergency Contact Information (other than the people noted above)

Name _____ Home Phone () _____
Work Phone () _____ Cell Phone () _____
Relationship to child: _____

Primary Care Physician Information

Current Physician _____
Physician Address _____
Physician Phone () _____ Physician Fax () _____
Emergency Resources
Medical: _____ Dental: _____

School Information

Current School _____ Primary teacher's name _____
Main contact at school _____ School phone number () _____