

**International Order Of The Rainbow For Girls in Pennsylvania  
Emergency Contact and Medical Information Form**

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Girl's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

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Parent/ \_\_\_\_\_ Home Number: \_\_\_\_\_  
Legal Guardian

Address \_\_\_\_\_

Cell Number \_\_\_\_\_ Work Number \_\_\_\_\_

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Parent/ \_\_\_\_\_ Home Number \_\_\_\_\_  
Legal Guardian

Address \_\_\_\_\_

Cell Number \_\_\_\_\_ Work Number \_\_\_\_\_

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Emergency Contact Other Than Parent \_\_\_\_\_

Phone Number(s) \_\_\_\_\_

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Please list anyone who is **NOT** authorized to pick up your child:

\_\_\_\_\_

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Physician Name \_\_\_\_\_ Contact Number \_\_\_\_\_

Health Insurance Provider \_\_\_\_\_

Policy Number \_\_\_\_\_

Name of Insured \_\_\_\_\_

**Please complete reverse side**

Please check the following boxes and then sign the bottom of this form in order for us to have written consent for medical care.

Yes    No   Emergency Medical Care

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Administration of Prescription Medications

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Administration of Non-Prescription Medications

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Please list any health concerns or special disabilities that we would need to be aware of:

  
  

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Please list any allergies (food or other) and the reaction that would occur:

  
  

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Signature of Parent or Legal Guardian

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Date