Emergency Contact & Medical Authorization

Child Information

Child's Full Name: ____________________

Date of Birth: ____________________ **Today's Date:** ____________________

Home Address: ____________________

City / State: ____________________ **ZIP:** ____________________

Parents / Guardians

Parent / Guardian #1 — Name: ____________________

Relationship: ____________________ **Cell Phone:** ____________________

Employer: ____________________ **Work Phone:** ____________________

Parent / Guardian #2 — Name: ____________________

Relationship: ____________________ **Cell Phone:** ____________________

Employer: ____________________ **Work Phone:** ____________________

Authorized Emergency Contacts & Pickup

List people (other than the parents/guardians above) who may be contacted in an emergency and who are authorized to pick up the child. The child will NOT be released to anyone not listed here without prior written notice.

Name	Relationship	Phone

Medical Information

Physician Name: ____________________

Physician Phone: ____________________ **Preferred Hospital:** ____________________

Dentist Name: ____________________

Dentist Phone: ____________________ **Insurance Provider / Policy #:** ____________________

Known Allergies (food, medication, environmental): ______________________________

Current Medications & Dosage: ____

Medical Conditions or Special Needs: ____

Emergency Medical Authorization

In the event of an emergency, and if I cannot be reached, I authorize the provider to secure necessary medical care for my child, including calling 911, arranging transport to a hospital, and permitting examination and treatment by emergency medical personnel. I understand I am responsible for any costs associated with such care.

Parent / Guardian Name (printed): ____

Signature: ________________________ **Date:** _____________________________