

Emergency Contact Information

Child's Name _____	Date of Birth ____/____/____			
Home Address _____	Street _____	City _____	State _____	Zip _____
Parent/Guardian _____	Name _____	Home # _____	Cell # _____	Work # _____
Parent/Guardian _____	Name _____	Home # _____	Cell # _____	Work # _____

Emergency Contacts (To whom child may be released if parent/guardian is unavailable)				
Name _____	Relationship _____			
Home # _____	Work # _____	Other _____		
Name _____	Relationship _____			
Home # _____	Work # _____	Other _____		
Child's Usual Source of Medical Care				
Physician's Name _____	Phone # _____			
Address _____	Street _____	City _____	State _____	Zip _____
Dentist's Name _____	Phone # _____			
Address _____	Street _____	City _____	State _____	Zip _____
Hospital Name _____	Phone # _____			
Address _____	Street _____	City _____	State _____	Zip _____

Child's Health Insurance _____
Subscribers Name _____ ID# _____

Allergies: _____

Specific Instructions of any special conditions: _____

As a parent/legal guardian, I give consent to _____ (program name) to administer to my child emergency first aid by the program staff. I understand that if necessary, 911 will be called and, my child may be transported to receive emergency care. I understand that I will be responsible for all emergency transportation and any charges not covered by insurance. I give consent for the emergency contact persons listed above to act on my behalf until I am available. I agree to update this information when changes occur.

Parent/Guardian's signature #1: _____ Date: ____ / ____ / ____

Parent/Guardian's signature #2: _____ Date: ____ / ____ / ____