EMERGENCY FORM

Provider's Name: _____

Child's First & Last Name: _____
Birthdate: _____
Mother's First & Last Name (or Guardian): _____
Address: _____ Phone: ( ) _____
Company Name & Address: _____
Hours: _____ Phone & ext. _____
Cellular phone: _____ Pager: _____

Father's First and Last Name (or Guardian): _____
Address: _____ Phone: ( ) _____
Company Name & Address: _____
Hours: _____ Phone & ext. _____
Cellular phone: _____ Pager: _____

IF ABOVE PERSONS ARE NOT AVAILABLE: Names and addresses of persons to be contacted and to whom the child may be released (must give three contacts):
Name: _____ Relationship: _____
Address: _____ Phone: _____
Name: _____ Relationship: _____
Address: _____ Phone: _____
Name: _____ Relationship: _____
Address: _____ Phone: _____

Family Physician's Name: _____ Phone: _____
Address: _____
Child's HEALTH CARD # _____
Hospital you prefer: _____
Are there any known allergies, health or medical conditions that the Provider should be made aware of? Circle YES or NO. If yes, please describe:

_____
_____
_____

PARENT'S CONSENT: If, at any time, due to such circumstances as accident, sudden illness emergency, and medical treatment is required, this may be given, including anesthetic, if necessary, by a private physician or hospital.
SPECIFIC INSTRUCTIONS OF PARENT/ GUARDIAN (i.e. Allergies, ongoing medicatic restrictions for treatment,
etc.): _____
_____

_____ _____

Signature of Parent/Guardian Date