Child's Name _____

EMERGENCY INFORMATION

CHILDREN WILL BE RELEASED ONLY TO PARENTS OR TO A PERSON DESIGNATED BY THE CHILD'S PARENTS. (THE DESIGNATED PERSON IS REQUIRED TO SHOW PHOTO IDENTIFICATION.)

Individuals authorized to pick up your child:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Individuals to call in an emergency situation if parents cannot be reached:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Authorization for Emergency Medical Attention

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the Beehive Director or person in charge to take my child to:

_____

Name of Physician Address Phone

_____

Name of Emergency Medical Care Facility Address Phone

_____

Name of insurance company (If required for non-emergency treatment) Group # Phone

I give consent for the facility to secure any and all necessary emergency medical care for my child.

_____

Signature – Parent or Legal Guardian