EMERGENCY CONTACT INFORMATION AND CONSENT FORM

Child Last Name: _____ First Name: _____ M.I. _____

Gender: [ ] Male [ ] Female Date of Birth: _____ Nationality: _____

SPECIAL CONDITIONS, DISABILITIES, ALLERGIES, OR MEDICAL EMERGENCY INFORMATION

_____

_____

EMERGENCY CONTACTS

Parent/Guardian

First Name: _____ M.I. _____ Last Name: _____

Physical Address: _____

Occupation: _____ Home Phone: :( ) _____

Employed By: _____ Cell Phone :( ) _____

Work Address: _____ Work Phone: :( ) _____

Parent/Guardian

First Name: _____ M.I. _____ Last Name: _____

Physical Address: _____

Occupation: _____ Home Phone: :( ) _____

Employed By: _____ Cell Phone :( ) _____

Work Address: _____ Work Phone: :( ) _____

Emergency Contact

First Name: _____ M.I. _____ Last Name: _____

Physical Address: _____

Occupation: _____ Home Phone: :( ) _____

Employed By: _____ Cell Phone :( ) _____

Work Address: _____ Work Phone: :( ) _____

PHYSICIAN OR MEDICAL FACILITY

Physician Name: _____

Clinic: _____ Telephone Number(s): _____

Insurance Company: _____ Policy Holder: _____

CONSENT

As parent/guardian, I consent to have my child receive first aid by facility staff and, if necessary, be transported to receive emergency care. I will be responsible for all charges not covered by insurance. I consent for the emergency contact person listed above to act on my behalf until I am available. I agree to review and update this information whenever a change occurs or at least every 6 months.

_____ _____ _____

Print Parent/Guardian Name **Signature** **Date**

_____ _____ _____

Print Parent/Guardian Name **Signature** **Date**