



EMERGENCY CARD INFORMATION

Child's Name: _____
Date of Birth: _____
Child's Home Address: _____
_____ Phone: _____

INSTRUCTIONS TO REACH PARENT/GUARDIAN

1. _____
(Name, Address, Phone #)
2. _____
(Name, Address, Phone #)

PEDIATRICIAN OR SOURCE OF HEALTH CARE

1. _____
(Doctor's Name, Address, Phone#)

EMERGENCY CONTACT PERSON(S)

1. _____
(Name, Address, Phone #)
2. _____
(Name, Address, Phone #)

MEDICAL EMERGENCY TREATMENT

I hereby give Scalliwags permission to administer basic first aid and/or CPR to my child

(Name)
and/or take my child _____, (name) to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

(Date)

(Parent Signature)

INSURANCE INFORMATION (OPTIONAL)

Company Name: _____ Policy # _____
Participating Hospital: _____
Special Instructions: _____



Topical Ointment Authorization Form

This form must be completed by the parent/guardian to authorize the use of

- Sunscreen
- Diaper ointment or cream
- Insect repellent
- Chapstick or lip balm
- Lotion
- Topical teething ointment or gel

Scalliwags and their staff have my permission to apply the over-the-counter (Name of Provider) skin product listed below to my child,

_____.

(Child's Name)

Over-the-Counter Skin Product Name:
When would you like the topical ointment applied?
Where would you like the topical ointment applied?
How much would you like applied? (check one) pea size dime size quarter size other: _____
Known adverse reactions (if any):

This authorization is effective from: _____ until: _____

(Start Date) *Permission may be given for up to 12 months.

_____ Parent's Signature

(End Date)

_____ Date