

## **HEALTH AND EMERGENCY PERMISSION RECORD**

Child's Name:			Birth Date:	
Address:			Home Phone:	
City: State: Zip Code:			Cell Phone:	
Email Address:			Additional Phone:	
Doctor's Name:			Phone:	
Does the child have physical problems, mental health disorders, or developmental disabilities, which would limit the child's participation in the program and activities?			Yes No	
Specify:				
Does the child have allergies or restrictions? (foods, medications, insects, etc.)			Yes No	
Specify:				
Are there any special procedures that are required in caring for the child?			Yes No	
Specify:				
Mom's emergency contact	Name:	Work:	Cell:	Other:
Dad's emergency contact	Name:	Work:	Cell:	Other:
Additional emergency contact	Name:	Work:	Cell:	Other:
I, child, harmless and rele	, in	give my permission for PACES to the event of an emergency if I lity. I further agree to keep the reached.	cannot be rea	ached, and to hold
Parent's signature			Date:	
<ol> <li>Contact p</li> <li>Contact p</li> </ol>	y medical procedure will parent person listed as emergen gency medical team, if r	cy contact		

- 3. Call emergency medical team, if necessary4. Have emergency medical team transport to nearest hospital
- 5. Will seek medical attention from:

Doctor: The doctor on call from the hospital, and the phone number of the hospital stated below: Hospital the center uses: Cone Health Med Center, 2630 Willard Dairy Rd., High Point, NC 27265