

### Alternate Pick-Up & Emergency Contact Information

All participants information must be completed on this form or will not accepted. The custodial party must designate an alternate competent adult to pick up the child(ren) should they be unavailable. Copy of valid driver's license is required on file for designee and must be obtainable to the supervisor upon request. **Note:** No child will be released to anyone with an expired driver's license and/or alcohol/drug consumption. A criminal history will be collected on alternate pick-up person. The designated adult must follow the same rules and guidelines as the custodial party.

\_\_\_\_\_ Number of child (ren) (Please List Child (ren) Names Below.

NAME OF CHILD (REN): \_\_\_\_\_

NAME OF CHILD (REN): \_\_\_\_\_

NAME OF CHILD (REN): \_\_\_\_\_

NAME OF CHILD (REN): \_\_\_\_\_

Alternate Pick-Up Person (must be someone other than the custodial party). Valid driver's license required.

Name:	Relationship:	Contact No:
Texas Driver's License No:	Texas Driver's License Expiration:	State:
Vehicle:	Make:	Year:                      Color:

**Place Copy of Driver's License of Alternate Pick-up Here or email copy into the office.**

#### Emergency Contact

Name:	Relationship:	Contact No:
Name:	Relationship:	Contact No:

Medical Emergency Release Form – Minor Child

I, \_\_\_\_\_, certify that I am the parent or legal guardian of the minor child listed below, and as such, I hereby convey temporary authority to the below designated Angel’s Harbor Supervised Visitation for the sole purpose of obtaining or arranging any emergency medical care for the minor child as may be deemed necessary for the well-being of my child when not accompanied by a parent/legal guardian or should either parent/legal guardian be unreachable by telephone.

THEREFORE, I hereby approve and empower Angel’s Harbor Supervised Visitation, Inc. with the authority to arrange and/or consent for all emergency medical care and treatment of my child in my absence.

1. Child’s Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

2. Child’s Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

3. Child’s Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

4. Child’s Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\* \_\_\_\_\_  
(Signature of Parent/Legal Guardian)

\_\_\_\_\_  
(Date)

\* \_\_\_\_\_  
(Relationship to Child)

\* \_\_\_\_\_  
(Home/Work Number)

\* \_\_\_\_\_  
(Cell Number)

### Authorization to Release Information

My child (ren) is participating in the Angel's Harbor Supervised Visitation Program, and I hereby authorize Angel's Harbor to make inquiries about my child (ren) from therapist, counselors, teachers, school, etc.

I hereby authorize the party receiving this form to disclose any information they may have relating to my child that may be requested by Angel's Harbor. Information received will become a permanent part of my child (ren) file at Angel's Harbor and will be treated as confidential by Angel's Harbor Office.

I waive my right to view this information and I release the party receiving this form from liability for providing this information.

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Staff initials: \_\_\_\_\_

Date: \_\_\_\_\_