Health Insurance Information

Insurance Name: _____

Policy Holder: _____

Group #: _____

Policy #: _____

MY LITTLE COLLEGE DAYCARE
STUDENT MEDICAL /FIELD TRIP TREATMENT CARD

CLASS _____ TEACHER _____

BIRTH DATE _____

IMMUNIZATION REQUIRED AS PER DSHS GUIDELINES; MUST COMPLETE TB QUESTIONNAIRE BEFORE ENROLLMENT

STUDENT'S NAME _____ (Last) _____ (First) _____ (MI)

LAST FIRST MIDDLE INITIAL

MOTHER/GUARDIAN'S NAME _____

HOME PHONE # _____

CELL # _____

ADDRESS _____

_____

BUSINESS PHONE # _____

BUSINESS ADDRESS _____

SOCIAL SECURITY # _____

FATHER/GUARDIAN'S NAME _____

HOME PHONE # _____

CELL # _____

ADDRESS _____

PLACE OF EMPLOYMENT _____

BUSINESS PHONE # _____

BUSINESS ADDRESS _____

SOCIAL SECURITY # _____

CONSENT FOR MEDICAL TREATMENT:According to the Family Code §35.01, consent for medical treatment may be given by a parent/guardian or any adult person when the parents cannot be contacted. Please list below an individual who may be contacted in the event that you are not available.

CONTACT ONE

NAME_____

PHONE_____

CELLULAR PHONE_____

ADDRESS_____

RELATIONSHIP_____

CONTACT TWO

NAME_____

PHONE_____

CELLULAR PHONE_____

ADDRESS_____

RELATIONSHIP_____

CONTACT THREE

NAME_____

PHONE_____

CELLULAR PHONE_____

ADDRESS_____

RELATIONSHIP_____

CONTACT FOUR

NAME_____

PHONE_____

CELLULAR PHONE_____

ADDRESS_____

RELATIONSHIP_____

HEALTH INFORMTION: List any helath conditions such as heart disease, diabetes, epilepsy, severe allergies, eye or ear problems or any chronic condition, etc.

Explanation: _____

_____

Doctor:(First Choice)_____ Telephone No. _____

Doctor:(Second Choice)_____ Telephone No. _____

Hospital Choice:_____ Telephone No. _____

TO THE PARENT OR LEGAL GUARDIAN: To serve your child in case of an accident, sudden illness or other need for immediate medical treatment, it is necessary that you indicate your consent to such treatment by your signature below.

I, the undersigned, do hereby authorize officals of MY LITTLE COLLEGE to contact directly the persons named on this card, and do authorize the name physician(s) to render such treatment as may be deemed necessary, for the health of said child.

In the event physicians, other persons named on this card, or parents cannot be contacted, the daycare officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of aforesaid child.

I will not hold the Daycare financially responsible for the emergency care and/or transportation for said child.

_____ Date

_____ Signature of Parent or Guardian