Emergency Card

Child's Name_____ D.O.B._____

Parent Name_____ Cell #_____

Address _____

Place of Employment_____ Work #_____

Parent Name_____ Cell #_____

Address _____

Place of Employment_____ Work #_____

Others Authorized to Pick Up / Emergency Pick Up

	NAME	Phone #	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

I authorize the treatment of anesthesia and surgical treatment for my minor child _____ in the event of a medical situation occurring during my absence or when the hospital or physicians are unable to contact me. This authorization extends to any hospital, physician and nursing personnel with the hospital as well as any physicians where treatments is rendered in the physicians' office. I release from medical responsibility and liability the hospital, medical authorities and physicians for performing treatments consent form, which are deemed necessary for my minor child.

_____	_____	_____
Physician	Address	Phone #
_____	_____	_____
Dentist	Address	Phone #

Daily Medications_____

Allergies_____

- In case of accidental poisoning, I give my permission to have syrup of Ipecac administered to my child, under consultation with the Poison Control Center. Y N

Please indicate which hospital you would like your child taken to: _____

_____ _____

Parent of Guardian Signature Date