VEHICLE EMERGENCY MEDICAL INFORMATION

Child's Name: _____ Date of Birth: ____

Address: _____

Father's Name: _____

Home Phone: _____ Work Phone: _____

Mother's Name: _____

Home Phone: _____ Work Phone: _____

Person to notify in an emergency and parents cannot be reached:

Name: _____ Work Phone: _____

Child's Doctor: _____ Work Phone: _____

Medical facility that center uses: _____

Address: _____

Child's Allergies: _____

Current prescribed medication: _____

Child's special needs and conditions: _____

In an event of an emergency involving my child, and if _____
Name of Facility

cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name: _____

Signature of Parent / Guardian: _____

Witness By: _____ Date: _____