Child's Name ____

EMERGENCY INFORMATION

CHILDREN WILL BE RELEASED ONLY TO PARENTS OR TO A PERSON DESIGNATED BY THE CHILD'S PARENTS. (THE DESIGNATED PERSON IS REQUIRED TO SHOW PHOTO IDENTIFICATION.)

Individuals authorized to pick up your child:

Name ____ Phone _________________

Name ____ Phone _________________

Name ____ Phone _________________

Individuals to call in an emergency situation if parents cannot be reached:

Name ____ Phone _________________

Address ____ Relationship ____________

Name ____ Phone _________________

Address ____ Relationship ____________

Authorization for Emergency Medical Attention

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the Beehive Director or person in charge to take my child to:

Physician's Name ____ Phone __________________

Physician's Address ____

Emergency Medical Care Facility ____

EMCF Address ____ Phone ____________________

Insurance Company _______________________________________ Phone ____________________

(If required for non-emergency treatment)

Policy/Group # ____

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Parent Signature ____