Emergency Contact Information

FORM E-100

Child's Name: _____ Date of Birth: ___/___/___

Home Address: _____
Street City State Zip

Parent/Guardian #1: _____
Name Home # Work # Other

Parent/Guardian #2: _____
Name Home # Work # Other

EMERGENCY CONTACTS

(To whom child may be released if parent/guardian is unavailable)

Name #1: _____ Relationship_____

_____
Address Home # Work # Other

Name #2: _____ Relationship_____

_____
Address Home # Work # Other

CHILD'S USUAL SOURCE OF MEDICAL CARE

Physician's Name: _____ Phone #: ( )_____

Address: _____
Street City State Zip

Dentist's Name: _____ Phone #: ( )_____

Address: _____
Street City State Zip

Hospital Name: _____ Phone #: ( )_____

Address: _____
Street City State Zip

Child's Health Insurance: _____

Subscribers Name (on insurance card): _____ ID #: _____

Specific instructions of special conditions, disabilities: _____

_____

Allergies: _____

As a parent/legal guardian, I give consent to _____ (program name) to administer to my child emergency first aid by the program staff. I understand that if necessary, 911 will be called and, my child may be transported to receive emergency care. I understand that I will be responsible for all emergency transportation and any charges not covered by insurance. I give consent for the emergency contact persons listed above to act on my behalf until I am available. I agree to update this information whenever a change occurs.

Parent/Guardian's signature #1: _____ Date: ___/___/___

Parent/Guardian's signature #2: _____ Date: ___/___/___