EMERGENCY CONTACT AND PARENTAL CONSENT

THIS FORM MUST BE TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED.

Child's Name:Address:	
Mother / Legal Guardian's Name:	Home Number:
Work Address:	Cell Number: Work Number:
Father / Legal Guardian's Name:	Home Number: Cell Number:
Work Address:	Work Number:
Emergency Contact Person:	Contact Number: Contact Number:
	Contact Number:
Health Insurance Carrier & Policy Number:	
Persons authorized to pick up child:	
Name:	Name:
Name:	Name:

- SEE REVERSE SIDE -

WRITTEN CONSENT IS GIVEN FOR:

Yes No EMERGENCY MEDICAL CA	ARE			
	DICATIONS		Medication Authorization form and Medication Administration Log Must be completed	
ADMINISTRATION OF NON-PRESCRIPTION MEDICATIONS		NS	OTC Medication Authorization Form and Medication Administration Log must be completed	
ADMINISTRATION OF SPECIAL DENTAL OF Please Specify:	R DIETARY N	EED	S:	
TRIPS: Yes No TRANSPORTATION BY THE FACILITY FOR TRIPS Yes No DAILY TRANSPORTATION PROVIDED BY THE FACILITY (Facility Has the Option to Offer) IF YOUR CHILD IS TRANSPORTED BY THE FACILITY, ARE THERE ANY INSTRUCTIONS FOR SPECIAL CARE FOR THE CHILD (I.E. MOTION SICKNESS, SEIZURES, ETC.) DURING TRANSPORTATION?				
HEALTH HISTORY				
Hay fever, asthma, or wheezing Eczema or frequent skin rashes Convulsions/Seizures Heart condition		0 0 0	YESNOChickenpoxDiabetesDiabetesTrouble with passing urine / bowelmovementFrequent colds, sore throats, earaches, tonsillitis, pneumonia	
Allergies or reaction: (food or other) Please Explain:	<u>YES 1</u>	<u>10</u>		
Other Health Concerns (special disabilities): Please Explain:	<u>YES 1</u>	<u>00</u>		