



HEALTH AND EMERGENCY PERMISSION RECORD

Child's Name:	Birth Date:
Address:	Phone:
Doctor's Name:	Phone:
Dentist's Name:	Phone:
Health Insurance Provider:	Phone:
Does the child have physical problems, mental health disorders, or developmental disabilities, which would limit the child's participation in the program and activities?	Yes <input type="radio"/> No <input type="radio"/>
Specify:	
Does the child have allergies? (foods, medications, insects, etc.)	Yes <input type="radio"/> No <input type="radio"/>
Specify:	
Are there any special procedures that are required in caring for the child?	Yes <input type="radio"/> No <input type="radio"/>
Specify:	

Emergency Contacts

1.		Relation		Phone: Cell:
2.		Relation		Phone: Cell:
3.		Relation		Phone: Cell:

Kids 'R' Kids #____ emergency medical procedure will be:

1. Contact parent
2. Contact person listed as emergency contact
3. Call emergency medical team, if necessary
4. Have emergency medical team transport to nearest hospital
5. Will seek medical attention from:

Doctor: *The doctor on call at the hospital stated below:*

Hospital the center uses:

Hospital Address:

I, _____ give my permission for Kids 'R' Kids #____ to seek medical attention for my child, _____, in the event of an emergency if I cannot be reached, and to hold harmless and release Kids 'R' Kids # ____ and Kids 'R' Kids International, Inc., from all liability. I further agree to keep the facility informed of changes in telephone numbers, etc., where I can be reached.

Parent's signature _____

Date: _____