EMERGENCY FORM

PLEASE TAKE THIS TO YOUR PROVIDER ON YOUR FIRST DAY

Provider's Name: ____

Child's First & Last Name: ____

________Birth date: _______________

Mother's First & Last Name (or Guardian): ___________________________

____

Address: ____Telephone #:

____

Company Name & Address: ____

____

Hours: _______________Telephone # & Extension: ______________________Mobile #:______________________

Father's First & Last name (or Guardian): ___________________________

____

Address:____Telephone #:_______________________________________

Company Name & Address: ____

____

Hours:_______________Telephone # & Extension:______________________Mobile #:_______________________________

IF THE ABOVE PERSONS ARE NOT AVAILABLE: Names & addresses of persons to be contacted and to whom the child may be released (must provide three contacts):

Name:____ Relationship:_______

____

Address: ____ Phone: _______

____

Name:____ Relationship:_______

____

Address: ____ Phone: _______

____

Family Physician's Name: ____

Phone: _______________________

Address: ____

____

Hospital you prefer: ____

____

Address: ____
____

Are there any known allergies, health or medical conditions that the Provider should be made aware of? Circle YES OR NO

If yes, please indicate: ____
____
____
____

PARENT'S CONCENT: If, at any time, due to such circumstances as accident, sudden illness or emergency, and medical treatment is required, this may be given, including anaesthetic, if necessary, by a private physician or hospital. SPEICIFIC OF PARENT/GUARDIAN (i.e. allergies, ongoing medication, restrictions for treatment, etc.):
____
____

____ _______
____

Signature of Parent/Guardian Signature of Witness

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