Vehicle Emergency Medical Information

Child's Name_____Date of Birth _____

Address _____

Father's Name_____Home Phone _____

Work Phone_____Cell Phone_____

Mother's Name_____Home Phone _____

Work Phone_____Cell Phone _____

Person to notify in case of an emergency when parents cannot be reached:

Name_____Phone _____

Child's Doctor_____Phone_____

Address of Medical Facility the Center Uses _____

_____

Child's Allergies _____

Current Prescribed Medication _____

Child's Special Medical Needs And Conditions _____

_____

In the event of an emergency involving my child, and if _____
(Facility Name)

cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during my child's treatment.

Child's Name _____

Printed name of Parent/Guardian _____

Signature of Parent/Guardian _____

Witnessed by_____Date _____