EMERGENCY CONTACT AND PARENTAL CONSENT

This form must be taken with the child when emergency medical care is needed.

Child's Name: _____ **Date of Birth:** _____

Physical Address: _____

Mailing Address: _____

Parents / Legal Guardians	
Mother/Legal Guardian:	Mobile Number: ❑ text ok
Physical Address:	Work Number:
Work Address:	Employer/Occupation:
Father/Legal Guardian:	Mobile Number: ❑ text ok
Physical Address:	Work Number:
Work Address:	Employer/Occupation:

Emergency Contacts		
Emergency Contact Names:	Contact Number:	Authorized to Pick-up Child?
1st)		❑ YES ❑ NO
2nd)		❑ YES ❑ NO
3rd)		❑ YES ❑ NO
4th)		❑ YES ❑ NO
A minimum of two emergency contacts are required who are authorized to pick-up your child.		

Medical Information & Health History			
Primary Physician:		Contact Number:	
Health Insurance Carrier:		Policy Number:	
Does your child have, or ever had any of the following?			
❑ YES ❑ NO	Hay Fever, Asthma, or Wheezing	❑ YES ❑ NO	Diabetes
❑ YES ❑ NO	Eczema or Frequent Skin Rashes	❑ YES ❑ NO	Trouble with Passing Urine/BM
❑ YES ❑ NO	Convulsions/Seizures	❑ YES ❑ NO	Earaches
❑ YES ❑ NO	Heart Condition	❑ YES ❑ NO	Sore Throats, or Tonsillitis
❑ YES ❑ NO	Chickenpox	❑ YES ❑ NO	Pneumonia
❑ YES ❑ NO	Allergies or Reactions - Please Specify:		
❑ YES ❑ NO	Other Health Concerns - Please Specify:		

Written Parental Consent is Given for:	
❑ YES ❑ NO	Emergency Medical Care
❑ YES ❑ NO	Administration of Prescription Medications - Medication Authorization Form/Log MUST be completed for each medication.
❑ YES ❑ NO	Administration of Non-Prescription Medications - OTC Medication Authorization Form and Log MUST be completed.
❑ YES ❑ NO	Administration of Special Dental Needs – Please Specify:
❑ YES ❑ NO	Administration of Dietary Needs - Please Specify:
❑ YES ❑ NO	Transportation by the program for trips - Special Care Notes:

_____

Signature of Parent or Guardian Print Date

Additional Notes: _____

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