Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____ Age_____

Child's Full Address _____

Mother's Name_____Home Phone _____

Work Phone_____Cell Phone _____

Father's Name_____Home Phone_____

Work Phone_____Cell Phone _____

Notify in an emergency if parents cannot be reached: *(LOCAL CONTACTS ONLY)*

Name_____Phone_____Relationship to Child _____

Name_____Phone_____Relationship to Child _____

Name_____Phone_____Relationship to Child _____

Child's Doctor _____Phone_____

Hospital Preference _____

Medical Facility the Center Uses _____

Child's Allergies _____

Current Prescribed Medications _____

Child's Special Needs and Conditions _____

In the event of an emergency involving my child and if Discovery Point cannot get in contact with me, I authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child,_____.

Parent(s)/Guardian Signature_____Date _____

Parent(s)/Guardian S i g n a t u r e _____Date _____

Owner/Director Signature_____Date _____