Emergency Contact and Medical Information for a Child

Child's Name	Date of Birth	Sex: M F

Parent's/Guardian's Name		Parent's/Guardian's Name	
Home/Cell Phone	Work Phone	Home/Cell Phone	Work Phone
Email		Email	
Address, City, ZIP Code		Address, City, ZIP Code	

Alternative Emergency Contacts

Primary Emergency Contact		Secondary Emergency Contact	
Home/Cell Phone	Work Phone	Home/Cell Phone	Work Phone
Email		Email	
Address, City, ZIP Code		Address, City, ZIP Code	

Medical Information

Hospital/Clinic Preference

Physician's Name	Phone Number
Insurance Company	Policy Number

Allergies/Special Health Considerations

Medications

Medical Conditions

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above named doctors or in the event the designated preferred practitioner is not available, by another licensed physician or dentist and (2) transfer of the child to any hospital reasonably accessible. The authorization does not cover major surgery, unless the medical opinions of two licensed doctors or dentists, concurring in the necessary for such surgery, are obtained prior to the performance of such surgery. Please list facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted on the lines above. Use back of sheet if necessary.

Parent's/Guardian's Signature	Date
Witness Signature	Date