

**INFANT AND PRE-SCHOOL
EMERGENCY & MEDICAL RECORD**

Room _____ Session _____ E. Date _____

CHILD'S NAME
(LAST NAME FIRST) _____
ADDRESS: _____
FATHER'S NAME: _____ DATE OF BIRTH: _____
EMPLOYER _____ HOME PHONE: _____
NAME & ADDRESS: _____ BUSINESS PHONE: _____
MOTHER'S NAME: _____ HOME PHONE: _____
EMPLOYER _____
(NAME & ADDRESS): _____ BUSINESS PHONE: _____

INCASE OF EMERGENCY: WHEN PARENTS OR GUARDIAN ARE NOT AVAILABLE CALL:

LOCAL FRIEND
OR RELATIVE: _____ PHONE: _____
LOCAL FRIEND
OR RELATIVE: _____ PHONE: _____

THESE PEOPLE SHOULD KNOW OF THIS PLAN

CHILD'S OR
FAMILY PHYSICIAN: _____ PHONE: _____
SUGGESTED HOSP.
(NAME & ADDRESS): _____ PHONE: _____

I, THE UNDERSIGNED PARENT OR GUARDIAN, HERBY GIVE MY CONSENT, IN THE EVENT OF AN EMERGENCY WHERE NEITHER I NOR MY FAMILY PHYSICIAN CAN BE CONTACTED FOR THE ABOVE NAMED CHILD TO BE TAKEN TO THE HOSPITAL

(Signature - Witness)

Date:

(Signature - Parent/guardian)

(Date)