

EMERGENCY CARD

Child's Name _____

D.O.B. _____

Address _____

Phone #

Parent Name _____

Home _____

Address _____

Cell _____

Place of Employment _____

Work _____

Employment Address _____

Parent Name _____

Home _____

Address _____

Cell _____

Place of Employment _____

Work _____

Employment Address _____

Authorized Pick-up

Name _____

Home _____

Address _____

Cell _____

Place of Employment _____

Work _____

Name _____

Home _____

Address _____

Cell _____

Place of Employment _____

Work _____

Emergency Pick-up

Name _____

Home _____

Address _____

Work _____

People Authorized to Visit

Name

Address

Relationship

- 1. _____
- 2. _____
- 3. _____
- 4. _____

- _____
- _____
- _____
- _____

I authorize the treatment of anesthesia and surgical treatment for my minor child _____ in the event of a medical situation occurring during my absence or when the hospital or physicians are unable to contact me. This authorization extends to any hospital and both physician and nursing personnel within the hospital as well as any physician where treatment is rendered in the physician's office. I release from medical responsibility and liability the hospital, medical authorities and physicians for performing treatments consent form, which are deemed necessary for my minor child.

Physician

Address

Phone

Dentist

Address

Phone

Daily Medications _____

Allergies _____

*In case of accidental poisoning, I give my permission to have syrup of Ipecac administered to my child, under consultation with the Poison Control Center. Please Circle: Y N

*I also give permission for the center to use sunscreen, insect repellent, hand lotion, and to use diapering products (wipes & ointments) supplied by parents/guardians as needed on my child. Please Circle: Y N

*I (we) give permission for my child to participate in field trips and other activities during operation hours. Y N

*I (we) hereby authorize you to use photographs of my child(ren) in slide shows, albums, and/or displays for public relations purposes for Little Miracles Please Circle: Y N

Please indicate the hospital you would like your child taken to: _____

Parent or Guardian Signature

Date