

# Wee Disciples Preschool Medical Emergency Form

Child's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip \_\_\_\_\_

Home phone #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Work phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**Name of relative or friend that could be contacted in case a parent cannot be reached:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

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Child's physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (include clinic name, if applicable): \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Child's dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies to medication or other allergies: \_\_\_\_\_

Medication (s) my child is currently taking: \_\_\_\_\_

Special instructions if child is injured or ill: \_\_\_\_\_

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**Medical Release:** I authorize Wee Disciples Preschool to seek emergency medical treatment for my child. I give permission to the emergency physician to secure proper emergency treatment and to order injection, anesthesia, or other emergency treatment if I (we) cannot be contacted. It is understood that a conscientious effort will be made to locate me or my spouse before action is taken. But if it is not possible to locate us, I accept the expense. In the event of a life-threatening emergency, I understand that "911" will be called to take my child to my preferred hospital \_\_\_\_\_ if possible, or to the closest available facility.

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date