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: _____

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: _____

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