



## Emergency Medical Information

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Child's name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Parent/Guardian name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Mobile phone \_\_\_\_\_ Email \_\_\_\_\_

Parent/Guardian name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Mobile phone \_\_\_\_\_ Email \_\_\_\_\_

Person to notify in case of emergency if parent/guardian cannot be reached:

Name \_\_\_\_\_ Phone \_\_\_\_\_

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

Medical facility the center uses \_\_\_\_\_

Address \_\_\_\_\_

Child's allergies \_\_\_\_\_

Current prescribed medication \_\_\_\_\_

Child's special needs and conditions \_\_\_\_\_

In the event of an emergency involving my child, and if Angels Academy cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's name \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_

Witnessed by \_\_\_\_\_ Date \_\_\_\_\_