



EMERGENCY CARE INFORMATION

CHILD INFORMATION

Name of Child _____ DOB _____

Address _____

Does your child have any allergies: No ___ Yes ___

Explain _____

Doctor's name _____ Phone number _____

FATHER'S INFORMATION

Name of father _____

Address _____

Home number _____ Cell _____ Work _____

MOTHER'S INFORMATION

Name of mother _____

Address _____

Home number _____ Cell _____ Work _____

If neither father nor mother (or guardian) can be contacted, call:

Name _____ Relationship _____

Cell number _____ home _____ Work _____

Name _____ Relationship _____

Cell number _____ home _____ Work _____

Signature _____ Date _____

If any information changes please update form and sign below:

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

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