



## Vehicle Emergency Medical Information

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Guardian 1 Name \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Number \_\_\_\_\_ Work Number \_\_\_\_\_

Guardian 2 Name \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Number \_\_\_\_\_ Work Number \_\_\_\_\_

Person to notify in an emergency when guardians listed above cannot be reached:

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

Child's Doctor \_\_\_\_\_ Phone \_\_\_\_\_

This center uses the following medical facility:

Child's Allergies \_\_\_\_\_

Current Prescribed Medication \_\_\_\_\_

Child's Special Needs & Conditions \_\_\_\_\_

In the event of an emergency involving my child, and if (name of center your child attends) \_\_\_\_\_ 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 \_\_\_\_\_