Child's Name _____
Date of Birth _____
Address _____
City _____ State ____ Zip _____
Home Phone _____ Email _____

Mother's Name _____
Work Phone _____ Cell Phone _____

Father's Name _____
Work Phone _____ Cell Phone _____

Emergency Contact Name _____
Relationship _____ Phone _____

Child's Physician _____
Physician's Address _____
Physician's Phone _____
Insurance Carrier _____ Policy # _____

I hereby authorize the medical treatment, administration of anesthesia and surgical treatments for my child, _____, in the event of a medical situation occurring during my absence or when the hospital or physician is unable to contact me.

_____
Parent's Signature Date