

## Vehicle Emergency Medical Information

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

Address \_\_\_\_\_

Father's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Person to notify in an emergency and parents cannot be reached:

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

Child's Doctor \_\_\_\_\_ 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 \_\_\_\_\_  
Name of Facility

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 \_\_\_\_\_

Signature (Parent/Guardian) \_\_\_\_\_

Witness By \_\_\_\_\_ Date \_\_\_\_\_