Emergency Medical Care

Child's Name: _____ Birthdate: _____

Parent's Name: _____ Emergency Tel: _____

Parent's Name: _____ Emergency Tel: _____

Address: _____

Allergies:_____ Last Tetanus _____

Insurance Carrier: _____

Insurance ID: _____

Physician to be called in an emergency:

Physican Name:_____

Practice Name: _____ Tel: _____

Address: _____

Dentist to be called in an emergency:

Physican Name:_____

Practice Name: _____ Tel: _____

Address: _____

I give my consent for Alphabet Academy to contact the above named physician/dentist if my child has a medical emergency. I understand that if my child's physician is not available, another physician may be contacted on an emergency basis. I also give my consent for the child care provider to seek medical attention in an emergency at _____. I will be responsible for all medical charges. (Hospital or walk-in clinic)

Parent Signature _____

Printed Name _____

Date _____

(Valid one year only)

Parent Signature _____

Printed Name _____

Date _____

(Valid one year only)

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