Vehicle Emergency Medical Information for Exempt Providers

Child's Name_____Date of Birth

Address _____

Father's Name _____

Home Phone _____ Work Phone _

Mother's Name _____

Home Phone _____Work Phone _

Alternate Delivery Location if a Parent NOT Home _____

Name of Person Authorized to Receive Child _____

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

Name _____Phone

Child's Doctor _____Phone

Medical Facility used by the Center _____

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 Program

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

Revised 09/24/24