



## Before/After Care Emergency Medical Emergency Release Information

### **Child's Information:**

Child's Full Name \_\_\_\_\_ Home Address: \_\_\_\_\_

Child's Physician \_\_\_\_\_

Physician's Address \_\_\_\_\_ Phone \_\_\_\_\_

### **Authorized Adults:**

In the event of an emergency, please list the names and numbers of both parents/guardians and two other authorized people. These numbers must be daytime numbers during WFCP operating hours.

Father's Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Alternate Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Alternate Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

January 2021

### **First Aid, Emergency Care & Health Records Transfer**

In the event of an emergency in which I/we cannot be reached or the above listed physician cannot be reached, I/we hereby authorize the staff of West Forsyth Christian Preschool to provide any emergency treatment deemed necessary for the life and health of my/our child. I/we understand that first aid may be needed and authorize the staff of West Forsyth Christian Preschool to provide necessary first aid.

In the event of an emergency, I/we hereby authorize the transfer of my/our child's health records to the local hospital.

Child's Date of Birth \_\_\_\_\_ Known Allergies \_\_\_\_\_

Special Medical Instructions \_\_\_\_\_

Hospital Preference In Case Of Emergency \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Policy# \_\_\_\_\_

Mother's Signature \_\_\_\_\_ Date \_\_\_\_\_

Father's Signature \_\_\_\_\_ Date \_\_\_\_\_

January 2021