

EMERGENCY AND TRANSPORTATION AUTHORIZATION

Provider's Information (use an address label) *Optional*

Name: _____

Address: _____

Phone: _____

Cell Phone: _____

Attach child's
photo here
Optional

Name of Child *	Date of Birth *
Name of Parent(s) / Guardian(s) *	Name of Parent(s) / Guardian(s) *
Complete Address, City, Zip	Complete Address, City, Zip
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Name of Alternate Contact *	Phone
Alternate's Address	Relationship to Child

Name of Physician

Phone

Clinic or Hospital

Name of Dentist

Phone

Health Insurance Carrier and Policy No.

Specific medical allergies, chronic illness, routine medication, blood type, or any medical condition

* I hereby authorize _____ or designated substitute to act on my behalf in obtaining emergency medical treatment for my child, _____, when I am unable to do so myself. All charges incurred are the responsibility of the parent(s).

* I authorize _____ to transport my child during child care hours for calendar year _____.

Signature of Parent or Guardian

Date

Signature of Parent or Guardian

Date