

EMERGENCY INFORMATION FORM

This form may be used for up to four children from one family. Please use the back of this form if you need more room to describe your child's special medical needs.

Child #1: Name _____ Date of Birth ___/___/___
 Allergies? NO YES if yes, please list: _____

Child #2: Name _____ Date of Birth ___/___/___
 Allergies? NO YES if yes, please list: _____

Child #3: Name _____ Date of Birth ___/___/___
 Allergies? NO YES if yes, please list: _____

Child #4: Name _____ Date of Birth ___/___/___
 Allergies? NO YES if yes, please list: _____

	NAME	ADDRESS	PHONE
MOTHER			
FATHER			
GUARDIAN			
	PLACE OF BUSINESS	BUSINESS ADDRESS	PHONE
MOTHER			
FATHER			
GUARDIAN			
	BEEPER NUMBER	BEEPER INSTRUCTIONS	CELLULAR #
MOTHER			
FATHER			
GUARDIAN			
	NAME	ADDRESS	PHONE
DOCTOR			

Who other than parents listed above may pick up the above named child(ren)?

NAME	RELATIONSHIP & PHONE NUMBER	NAME	RELATIONSHIP & PHONE NUMBER
1.		2.	

I give permission for office personnel to administer topical ointment (i.e. Neosporin; Calamine Lotion, Bacitracin Ointment or Benadryl Lotion.)

 Parent's or Guardian's Signature

 Date