EMERGENCY FORM

FOR MEDICAL EMERGENCIES & POWER OF ATTORNEY FOR:

To Whom it May Concern:

We, the parents or legal guardians of ____, hereby

General Information

Child's Name:______________________ Birthdate:_________________ Age:_____________

Child's Home Address:________________________ City:___________ Zip Code:________

Does child live with both parents?_____If no, please describe:___________________________

____

Mother's Name:___________________________________ Home Phone:________________

Mother's Address:_________________________________City:____________ Zip Code:_________

Mother's Occupation:______________________________Work Phone:_________________

Mother's Cell Phone:_______________________________Mother's Pager #:__________________

Father's Name:____________________________________ Home Phone:_________________

Father's Address:__________________________________ City:____________ Zip Code:_________

Father's Occupation:_______________________________Work Phone:_________________

Father's Cell Phone:_______________________________ Father's Pager #:__________________

Insurance Information

Insurance Company:____________________ Employer's Name:_________________________

Policy Number:________________________ Group Number:___________________________

Insured's Name:_______________________ Type of Coverage:_________________________

Phone Number for Claims:_______________ Phone Number for Emergency Care:__________

Address for Claims:_____________________ City:_________________ Zip Code:__________

Personal Information

Friend who will most likely know how to reach us in case of emergency:_____________________

Friend's Home Phone: (____)_____________ Friend's Work Phone:(____)_________________

Closest Relative:________________________ Relationship to Child:________________________

Relative's Home Phone:(____)____________ Relative's Work Phone:(____)________________

Disaster Plan

In case school evacuation is necessary and local phone lines are not operating, please call 877.357.5655 and leave a message. We will make all efforts to contact parents or contact person (out-of-state) by phone.

Contact Person: ____

Home Phone:___________________________ Work Phone:______________________________

Disaster Plan Information you would like us to have:____________________________________

____

____

Medical Information

Pediatrician's Name:________________________________ Phone:__(____)________________

Pediatrician's Address:_________________________ City:____________ Zip Code:_________

Family Doctor's Name:______________________________ Phone:__(____)________________

Family Doctor's Address:______________________ City:____________ Zip Code:_________

Dentist's Name:____________________________________ Phone:__(____)________________

Dentist's Address:____________________________ City:____________ Zip Code:_________

Orthodontist's Name:________________________________ Phone:___(____)_______________

Orthodontist's Address:_________________________ City:____________ Zip Code:_________

Other Specialist's Name:_____________________________ Phone:___(____)_______________

Other Specialist's Address:_____________________ City:____________ Zip Code:_________

My child has had all immunizations required for his/her age except:________________________

____

____

My child is allergic to:____

____

My child is on the following medications:____

____

____

My child's blood type is:____________________ The following people have the same blood type:

Donor's Name:____________________ Phone:_______________ Relationship:______________

Donor's Name:____________________ Phone:_______________ Relationship:______________

If my child receives emergency medical attention to his/her face a plastic surgeon may be involved in the decision making process to avoid cosmetic surgery at a later date. I would _____/ would not _____ like a plastic surgeon involved in the medical care my child receives.

If hospitalization is necessary, please go to _________________________, if there is a choice.

Medical information I would like emergency physicians to know:__________________________

____

____

Miscellaneous Information

____

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All of the above is true to the best of my knowledge. I agree to be financially responsible for any emergency treatment given to my child.

_____________________________ ____

Date Parent's or Legal Guardian's Signature