



EMERGENCY MEDICAL CARE

Child Daycare Center Licensing

Attention Provider: Carry a copy of this form and the Child Health Care Record during any off-premises child care activity. Please verify with the emergency medical care facility to assure that this form is acceptable.

Child's
Name: _____ Birthdate: _____

Mother's Name: _____ Emergency Phone# _____

Father's Name _____ Emergency Phone# _____

Address: _____

Town: _____

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Allergies: _____ Date of Last Tetanus: _____

Insurance
carrier: _____

Insurance
ID# _____

Physician to be called in an emergency:

Name: _____ Telephone: _____

Address: _____ Town: _____

I give my consent for Surreybrook Preschool and Child Development Center to contact the above named physician if my child has a medical emergency. I understand that if my child's physician is not available, another physician may be contacted on an emergency basis. I will be responsible for all medical charges.

Signature

Date

Printed Name

(Valid one year only)