THE SURREYBROOK SCHOOL

EMERGENCY MEDICAL CARE

Child Daycare Center Licensing

Child's Name:_____Birthdate:_____

Parent Name:_____Emergency Phone#_____

Parent Name_____ Emergency Phone#_____

Address:_____

Town:_____

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)
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.