

# Emergency Card Information

Child's Last Name \_\_\_\_\_ Child's First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Child's Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

## INSTRUCTIONS TO REACH PARENT/GUARDIAN

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Phone \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Phone \_\_\_\_\_

## PEDIATRICIAN OR SOURCE OF HEALTH CARE

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

## LOCAL EMERGENCY CONTACT PERSON(S)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Phone \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Phone \_\_\_\_\_

## MEDICAL INFORMATION

List any allergies, chronic health conditions, medications, or write "NONE".

\_\_\_\_\_  
\_\_\_\_\_

## INSURANCE INFORMATION (OPTIONAL)

Company Name \_\_\_\_\_ Policy # \_\_\_\_\_ Participating Hospital \_\_\_\_\_

Special Instructions \_\_\_\_\_

## MEDICATION AUTHORIZATION AND CONSENT

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I/we cannot be reached, I hereby authorize Angier After School Program to transport my child to the Hospital (by ambulance if the situation warrants) and to secure for my child the necessary medical treatment. I understand the teachers at AASP are trained in the basics of First Aid and CPR and I authorize them to give my child first aid and/or CPR when appropriate.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_