



A Child's Journey School

Emergency information

Child's Name: _____ Birthday: _____ Start date: _____

Home Address: _____

Mother's Name: _____ Mobile: _____ Work: _____

Father's Name: _____ Mobile: _____ Work: _____

Alternate Emergency Contact Persons

Name: _____ Phone: _____ Hospital Preference: _____

Name: _____ Phone: _____ Child's Doctor: _____

Name: _____ Phone: _____ Doctor Phone: _____

Medical information. (Allergies to medications, food, other substances, etc.):

I agree that the operator may authorize the physician of his/her choice to provide emergency medical care in the event that neither I, my spouse, alternate contact(s), nor my child's doctor can be located immediately.

Parent's Signature: _____ Date: _____

Operator's Signature: _____ Date: _____