

**EMERGENCY MEDICAL INFORMATION**

**TO BE TAKEN ON ALL FIELD TRIPS**

PLEASE PRINT

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

GUARDIAN'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

**IN CASE OF EMERGENCY AND PARENTS/GUARDIAN CANNOT BE REACHED, CALL:**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

CHILD'S DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

**THIS CENTER USES, WHEN APPROPRIATE, SCOTTIS RITE HOSPITAL, 1001 JOHNSON FERRY ROAD, ATLANTA, GA 30342. PHONE # 404-256-5252.**

CHILD'S ALLERGIES \_\_\_\_\_

FREQUENCY AND SYMPTIONS \_\_\_\_\_

CURRENT PRESCRIBED MEDICATION \_\_\_\_\_

OTHER SPECIAL MEDICAL NEEDS AND CONDITIONS \_\_\_\_\_

**In the event of an emergency involving my child, and Apostles Lutheran Child Development Center cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.**

ACCEPTED BY \_\_\_\_\_ PARENT OR GUARDIAN

DATE \_\_\_\_\_

ALCDC ACCEPTED BY \_\_\_\_\_

DATE \_\_\_\_\_

WITNESS \_\_\_\_\_