



EMERGENCY INFORMATION

2020-2021

Name of Child _____ Date of Birth: _____

Medical Conditions and/or Medications: _____

Parent/Guardian _____ Parent/Guardian _____

Cell Phone _____ Cell Phone _____

Office Phone _____ Office Phone _____

Home Phone _____ Home Phone _____

Address: _____ Address: _____

EMERGENCY CONTACTS

Names of persons who would assume responsibility for your child **if you cannot be reached**, including permission to take your child from the Center. Two different emergency contacts must be on file for your child.

(1) Name _____ Phone ^(PRIMARY) _____

Address _____ Phone _____

Relation to the Child: _____

(1) Name _____ Phone ^(PRIMARY) _____

Address _____ Phone _____

Relation to the Child: _____

MEDICAL EMERGENCY TREATMENT

I hereby give the BU Children's Center permission to administer basic first aid and/or CPR to my child, _____ (Child's Name), and/or take my child to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

(Parent/Guardian Signature)

(Date)

INSURANCE INFORMATION

Company Name: _____ Policy #: _____

Participating Hospital: _____

Special Instructions: _____

Pediatrician (Name): _____ Phone: _____

Address: _____