Emergency Contact Form

Child's Name:_____ Date:_____

Date of Birth:_____

Allergies/Sensitivities:

- ☐ Yes
- ☐ No

If yes, please list:_____

Parent/Guardian Name:_____ Address:_____ _____ Phone:_____ Work:_____	**Parent/Guardian** Name:_____ Address:_____ _____ Phone:_____ Work:_____
Emergency Contact (in case parent cannot be reached) Name:_____ Relationship to Child:_____ Phone:_____	**Emergency Contact** (in case parent cannot be reached) Name:_____ Relationship to Child:_____ Phone:_____

Doctors Name:_____ Phone:_____

I give consent for my child to be treated in case of an emergency.

Signature:_____ Date:_____