Disaster/Earthquake Emergency Information

Child's Name____________________________Birthdate_______________
Address____
Home Phone_______________________
Mother's Name_________________________work phone___ ___________
Cell phone_________________________
E-mail____

Father's Name__________________________work phone______________
Cell phone________________________
Email____

Physician__________________________phone______________________
Hospital___________________________phone______________________
Dentist____________________________phone______________________
Allergies____
Out of area contact person _______________________________________
Phone _________________________________relationship _____________

Consent for Emergency Medical Treatment

As the Parent or Authorized Representative, I hereby give consent to

____to obtain all emergency Medical or
Facility name

Dental Care prescribed by a duly licensed Physician (MD) Osteopath (DO) or Dentist (DDS) for

____. This care may be given under whatever
Name
conditions are necessary to preserve the life, limb or well begin of the child named above. We hereby give out permission for Full of Wonder to take him/her out of the facility either on foot or by car.

____ ____________________
Parent/guardian date

____ ____________________
Parent/guardian date