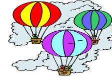

Emergency Card/Authorization for Medical Treatment

<u>Name of Child</u>: ______________________________ Date of Birth: ______________________________

Home Address: ______________________________ Postal Code: ____________

<u>Mother Name</u>: ____________________ Home Address: ____________________ Postal Code: ____________

Home Phone: ____________________ Cell Phone: ____________________Work Phone: ____________

Place of Work: ____________________ Work Address: ____________________ Postal Code: ____________

<u>Father Name</u>: ____________________ Home Address: ____________________ Postal Code: ____________

Home Phone: ____________________ Cell Phone: ____________________Work Phone: ____________

Place of Work: ____________________ Work Address: ____________________ Postal Code: ____________

<u>Alternate Name</u>: ____________________ Home Address: ____________________ Postal Code: ____________

Home Phone: ____________________ Cell Phone: ____________________Work Phone: ____________

Place of Work: ____________________ Work Address: ____________________ Postal Code: ____________

Authorization for Medical Treatment

Dr. Name: ____________________ Clinic Address: ____________________ Clinic Phone: ____________________

AHC #: ____________________ Immunizations Up To Date: Yes: __________ No: __________

Allergies/Special Medical Conditions/Regular Medication: ______________________________

____

Person Authorized to Pick Up Child: ______________________________

<u>Emergency Medical Treatment</u>: In the event of an emergency when I am not available, I authorize the administration of any medical procedures deemed necessary by my doctor, or, if unavailable, by any other physician selected by the Director/Designate of the Day Care Centre.

Parent Name: ____________________ Parent Signature: ____________________ Date: ____________________

Revised June 15, 2017