



Emergency Card/Authorization for Medical Treatment



Name of Child: _____ Date of Birth: _____

Home Address: _____ Postal Code: _____

Mother Name: _____ Home Address: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Place of Work: _____ Work Address: _____ Postal Code: _____

Father Name: _____ Home Address: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Place of Work: _____ Work Address: _____ Postal Code: _____

Emergency Contact: _____ 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: _____

Emergency Medical Treatment: 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: _____