

INFORMATION FOR EMERGENCY / FIELD TRIP

_____	_____	____/____/____	_____
Child's Last Name	First Name	Birth date	Age

_____	_____	_____
Street Address	City	Zip Code

_____	_____	_____	_____
Parent #1	Home Phone #	Work Phone #	Cell Phone #
Email _____			

_____	_____	_____	_____
Parent #2	Home Phone #	Work Phone #	Cell Phone #
Email _____			

_____	_____	_____
Physicians Name	Address	Phone #

In case of serious illness or accident and neither parent can be contacted. Do you give A Child's Way permission to obtain ambulance service and/or medical treatment for your child?

Yes _____ Signed _____ Date _____

PERSONS AUTHORIZED TO PICK-UP YOUR CHILD FROM A CHILD'S WAY

_____	_____	_____	_____
Name (relationship)	Home Phone #	Work Phone #	Cell Phone #

_____	_____	_____	_____
Name (relationship)	Home Phone #	Work Phone #	Cell Phone #

_____	_____	_____	_____
Name (relationship)	Home Phone #	Work Phone #	Cell Phone #

Date of last tetanus shot _____

Please list any fears or allergies your child has: _____
