Emergency Contact Card

PLEASE PRINT

Child's Full Name _____

DOB _____ Allergies (Medication/Food) _____

Address _____

Mother's Name _____ Home # _____

Work # _____ Cell # _____

email address _____

Father's Name _____ Home # _____

Work # _____ Cell # _____

email address _____

I hereby authorize the following person(s) to be contacted incase of emergencies as well as child pick up from DLC.

Name _____ Relation _____

Address _____

Home # _____ Cell # _____

Description _____

Name _____ Relation _____

Address _____

Home # _____ Cell # _____

Description _____

--Please extend on back of card if needed.--

Authorization for Emergency Medical Care

If I cannot be reached to make arrangements for emergency medical care for my child at the time of an illness or accident, I give my permission for:

Discovery Learning Center

to take my child (or children):

_____ _____

_____ _____

to the following doctor:

_____ #_____

Office Address _____

or to the following hospital:

_____

Hospital Address _____

I give my consent for necessary emergency treatment when my child is in the care of this physician/clinic and/or hospital.

_____ _____

Signature of Parent/Legal Guardian Date

I give permission for Discovery Learning Center to photograph my child for campus use only.

Parent's Signature: _____ Date:_____