



**TARA REDWOOD SCHOOL CHILD EMERGENCY INFORMATION**

Child's Last Name: \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ M / F DOB: \_\_\_\_

Home address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home/day - Phone \_\_\_\_\_

**Parent #1 Full Name:** \_\_\_\_\_ Employer \_\_\_\_\_

\_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email \_\_\_\_\_

**Parent #2 Full Name:** \_\_\_\_\_ Employer \_\_\_\_\_

Phone/Email: \_\_\_\_\_

\_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email \_\_\_\_\_

With whom does the child live? \_\_\_\_\_ Are there custody arrangements? If Yes (Please attach documents)

Name \_\_\_\_\_ DOB: \_\_\_\_\_

Name \_\_\_\_\_ DOB: \_\_\_\_\_

**ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph #s \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph #s \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph #s \_\_\_\_\_

Primary Doctor \_\_\_\_\_ Ph# \_\_\_\_\_ Dentist \_\_\_\_\_ Ph# \_\_\_\_\_

Does *your* child currently have medical insurance? Yes No

If yes, please state the Insurance carrier & number: \_\_\_\_\_

**NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY**

(Child WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph#s \_\_\_\_\_  
 \_\_\_\_\_ Phone #1 \_\_\_\_\_ Phone#2 \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph#s \_\_\_\_\_  
 \_\_\_\_\_ Phone #1 \_\_\_\_\_ Phone#2 \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph#s \_\_\_\_\_  
 \_\_\_\_\_ Phone #1 \_\_\_\_\_ Phone#2 \_\_\_\_\_

**CONSENT FOR EMERGENCY MEDICAL TREATMENT**

As the parent or authorized representative, I hereby give consent to provide all emergency dental or medical care prescribed by a duly licensed physician (M, D.), Osteopath (D.O.) or Dentist (D.D.S.) for: *my* child named above. This care *may* be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent

Child has the following illnesses: \_\_\_\_\_

Child has the following allergies: \_\_\_\_\_

Child regularly takes the following medication: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_