SERVING ALL OF GOD'S CHILDREN
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Light of Christ Preschool Emergency Contact and Medical Information

Child's Name_____ Date of Birth _____

Sex: M F

Parent/Guardian Name _____ Parent/Guardian Name_____

Phone_____ Phone _____

Address _____ Address _____

City, State, Zip_____ City, State, Zip _____

Alternative Emergency Contact

Primary Emergency Contact_____

Phone Number_____

Address _____

City, State, Zip_____

Secondary Emergency Contact _____

Phone Number _____

Address _____

City, State, Zip _____

Medical Information

Hospital/Clinic Preference_____

Physician Name_____ Phone Number_____

Insurance Company _____ Policy Number _____

Allergies/Special Health Considerations_____

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only if neither parent/guardian can be reached in case of emergency.

Parent/Guardian's Signature_____ Date_____