

# Longwood Medical Area Child Care Center

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## EMERGENCY CARD INFORMATION

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

Phone: \_\_\_\_\_

### INSTRUCTIONS TO REACH PARENT/GUARDIAN

1. \_\_\_\_\_  
(Name, Address, Phone #)

2. \_\_\_\_\_  
(Name, Address, Phone #)

### PEDIATRICIAN OR SOURCE OF HEALTH CARE

1. \_\_\_\_\_  
( Doctor's Name, Address, Phone #)

### EMERGENCY CONTACT PERSON(S)

1. \_\_\_\_\_  
(Name, Address, Phone #)

2. \_\_\_\_\_  
(Name, Address, Phone #)

### MEDICAL EMERGENCY TREATMENT

I hereby give \_\_\_\_\_  
(Name of program)

Permission to administer basic first aid and/or CPR to my child  
\_\_\_\_\_ and/or take my child \_\_\_\_\_ ,  
(Name) (Name)

to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

\_\_\_\_\_  
(Parent Signature)

\_\_\_\_\_  
(Date)

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## **INSURANCE INFORMATION (OPTIONAL)**

Company Name: \_\_\_\_\_ Policy # \_\_\_\_\_

Participating Hospital: \_\_\_\_\_

Special Instructions:

\_\_\_\_\_

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