

Emergency Card 2010

Child's Name: _____

Home Phone Number: _____

Date of Birth: _____

Home Address: _____

Hair Color: _____ Eye Color: _____

Mother's Name: _____

Phone # _____ (If different than above)

Place of Employment: _____

Address

Phone Number

Father's Name: _____

Phone # _____ (If different than above)

Place of Employment: _____

Address

Phone Number

Picture
Please put a
photo of your
child in this box.

Child's Doctor: _____

Phone # _____

Child's Dentist: _____

Phone # _____

Hospital of Choice: _____

Emergency contact to call if parent can not be reached and medical authorization may be obtained:

Name: _____

Phone # _____

Address: _____

Relationship: _____

Name: _____

Phone # _____

Address: _____

Relationship: _____

Name: _____

Phone # _____

Address: _____

Relationship: _____

Any Allergies or Health Problems we need to be aware of: _____

Special Instructions: _____

Medications: _____

Emergency Medical Authorizations:

I, _____, Hereby give my permission to the City of Broomfield Staff to call a doctor for medical or surgical care for my child, _____, should an emergency situation arise. It is understood that a conscious effort will be made to locate me or my spouse before any action will be taken, but if it is not possible to locate us, this expense will be accepted by us.

Signature of Parent or Legal Guardian

Date

PERSON'S AUTHORIZED TO PICK UP CHILD (include yourself):

1. _____
Name/Phone #

2. _____
Name/Phone #

3. _____
Name/Phone #

4. _____
Name/Phone #

5. _____
Name/Phone #