MEDICAL AND EMERGENCY

CHILD' S NAME: _____ _____ _____
[Last] [First] [Middle]

NATIONALITY: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

FATHER' S NAME: _____ TEL: _____

MOTHER' S NAME: _____ TEL: _____

HOME ADDRESS: _____

FAMILY PHYSICIAN: _____ TELEPHONE: _____

IN CASE OF EMERGENCY CONTACT: _____

ADDRESS: _____ TELEPHONE:_____

MEDICAL HISTORY

FOOD ALLERGIES:_____MEDICATION ALLERGIES:_____

OTHER ALLERGIES: _____

ASTHMA: _____ HOSPITALIZATIONS: _____

CULTURAL & /OR DIETARY RESTRICTIONS: _____

EMERGENCY RELEASE FORM

In case of an emergency and I cannot be reached, the Early Childhood Learning Centre has my permission to obtain emergency medical care for my child :

Name of Child: _____ Date: _____

In case of emergency and I cannot be reached, I authorize the staff of ECLC to obtain whatever medical treatment deemed necessary for the welfare of my child. I further understand and agree that I will be financially responsible for all charges and fees incurred in the rendering of said emergency treatment.

ECLC
Early Childhood Learning Centre

_____
Signature of Parent or Guardian