UD Lab School Emergency Information

**Type directly into this form in the gray boxes.**

Child’s Name:

Date of Birth:

**Parent/Guardian Contact Information:**

|  |  |
| --- | --- |
| Name:       | Name:       |
| Relation:       | Relation:       |
| Address:      | Address:      |
| City,/State, Zip:       | City,/State, Zip:       |
| Cell Phone#:        | Cell Phone#:        |
| Home Phone#:       | Home Phone#:       |
| Work Phone:       | Work Phone:       |
| Email:       | Email:       |

**The following individuals may pick up my child if parents/guardians can’t be reached:**

|  |  |
| --- | --- |
| Name:       | Name:       |
| Relation:       | Relation:       |
| Cell Phone#:        | Cell Phone#:        |
| Home Phone#:       | Home Phone#:       |
| Work Phone:       | Work Phone:       |

**Name of child’s physician**:

**Physician’s phone#:**

**Allergy and special medical information** (include medicine/food allergies and other significant medical information):

**Health Insurance Company:**

**Insurance Identification Number:**

**Emergency Medical Care:**

[ ]  (Check box) I authorize emergency medical treatment for my child in the event I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment. I further give permission for my child to be transported with his/her caregiver in an emergency vehicle in the event of such emergency. I understand that I will be financially responsible for such emergency vehicle, if applicable.

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

*actual signature required*