



EMERGENCY INFORMATION FORM

CHILD'S NAME:

BIRTHDATE:

CHILD'S PHYSICIAN:

PHYSICIAN'S ADDRESS:

PHYSICIAN'S PHONE:

HOSPITAL PREFERENCE:

CHILD'S DENTIST:

DENTIST'S ADDRESS:

DENTIST'S PHONE:

PEOPLE WHOM WE MAY CALL IN CASE OF EMERGENCY (OTHER THAN PARENTS)

1. NAME:

ADDRESS:

CITY & ZIP:

PHONE:

RELATIONSHIP:

2. NAME:

ADDRESS:

CITY & ZIP:

PHONE:

RELATIONSHIP:

UNDER NO CIRCUMSTANCES WILL YOUR CHILD BE RELEASED TO ANYONE NOT KNOWN TO THE CENTER WITHOUT AUTHORIZATION FROM PARENTS/GUARDIANS.

OTHER PEOPLE WHO MAY REMOVE MY CHILD FROM THE CENTER:

1. NAME:
ADDRESS:
CITY & ZIP:
PHONE:
RELATIONSHIP:

2. NAME:
ADDRESS:
CITY & ZIP:
PHONE:
RELATIONSHIP:

3. NAME:
ADDRESS:
CITY & ZIP:
PHONE:
RELATIONSHIP:

PERMISSION IS GRANTED FOR STEPPING STONES TO ALLOW DOCTOR OR HOSPITAL PERSONNEL TO TREAT YOUR CHILD AS DEEMED NECESSARY. PARENTS WILL BE CONTACTED IMMEDIATELY.

SIGNATURE OF PARENT/GUARDIAN

DATE

SIGNATURE OF PARENT/GUARDIAN

DATE

IN THE EVENT OF POISONING WE MAY GIVE YOUR CHILD SYRUP OF IPPECAC ONLY UNDER THE DIRCTION OF THE POISON CONTROL CENTER.

SIGNATURE OF PARENT/GUARDIAN

YES

NO