



EMERGENCY CONTACT INFORMATION

Child's Name: _____

Date of Birth: _____

1. Name of Parent/Guardian: _____ Relationship _____

2. Parent/Guardian Phone #: Cell (____)-____-____

Home (____)-____-____

Business (____)-____-____

Email _____

3. Name of Parent/Guardian: _____ Relationship _____

4. Parent/Guardian Phone #: Cell (____)-____-____

Home (____)-____-____

Business (____)-____-____

Email _____

5. In case Parent/Guardian cannot be reached, please contact: _____

Relationship: _____ Telephone Number: (____)-____-____

6. Please list any insurance policy covering your child: _____

Policy Number: _____

7. Physician's Name _____ Telephone Number: (____)-____-____

8. *Only if Applicable, complete the following:*

• My Child has the following medical problem: _____

• My Child takes the following medications regularly: _____

• My Child Has the following allergies: _____

I AUTHORIZE MEDICAL TREATMENT FOR MY CHILD IN CASE OF ACCIDENT OR ILLNESS WHILE IN THE CARE OF MARP.

Parent/Guardian Signature: _____ Date: _____