MEDICAL EMERGENCY FORM
Waypoint Preschool

Child's Name _____Birth date _____
Address_____
Phone _____
Mother's Name _____
Daytime Phone _____Cell phone/pager_____
Father's Name _____
Daytime Phone _____Cell phone/pager_____

Special Health Information (include all allergies, reactions, seizures, etc.) This must be completed. If there are none, please write "NONE."

_____
_____
_____

In case of emergency, if parents can't be reached, please name two persons, who reside locally, who could pick your child up at school and give temporary care if he/she becomes ill.
Name _____Relationship _____
Home Phone _____Cell phone/pager_____
Name _____ Relationship _____
Home Phone _____Cell phone/pager_____

Other Medical Information:
Physician's Name _____ Phone _____
Dentist's Name _____ Phone _____
Hospital Preference_____
Insurance Company _____ Policy #_____

I understand that every effort will be made to contact me in case of an emergency, and, if possible, before any medical treatment is administered. In the event of an emergency, I hereby give permission to Waypoint Preschool to secure proper treatment for my child as named on this form.

If necessary, this includes selection of physician and closest appropriate medical treatment facility who are then authorized to perform such medical treatments as deemed necessary to protect the health of my child. I hereby release Waypoint Preschool from any responsibility other than normal supervision and care. In case of accident, I will not hold Waypoint Preschool, its staff members, management, or officers liable for securing such treatment.

Signature of Parent or Guardian _____ Date _____