MIAMI AUTISM RECOVERY PRESCHOOL

EMERGENCY CONTACT INFORMATION

Child's Name: _____

Date of Birth: _____

1. Name of Parent/Guardian: _____ Relationship_____
2. Parent/Guardian Phone #: Cell (__ __ __)-__ __ __- __ __ __ __
   Home (__ __ __)-__ __ __- __ __ __ __
   Business (__ __ __)-__ __ __- __ __ __ __
3. Name of Parent/Guardian: _____ Relationship_____
4. Parent/Guardian Phone #: Cell (__ __ __)-__ __ __- __ __ __ __
   Home (__ __ __)-__ __ __- __ __ __ __
   Business (__ __ __)-__ __ __- __ __ __ __
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: _____