HEALTH AND EMERGENCY PERMISSION RECORD

Child's Name:	Birth Date:
Address:	Home Phone:
City: State: Zip Code:	Cell Phone:
Email Address:	Additional Phone:
Doctor's Name:	Phone:
Does the child have physical problems, mental health disorders, or developmental disabilities, which would limit the child's participation in the program and activities?	Yes No
Specify:	
Does the child have allergies or restrictions? (foods, medications, insects, etc.)	Yes No
Specify:	
Are there any special procedures that are required in caring for the child?	Yes No
Specify:	

Mom's emergency contact	Name:	Work:	Cell:	Other:
Dad's emergency contact	Name:	Work:	Cell:	Other:
Additional emergency contact	Name:	Work:	Cell:	Other:

I, _____give my permission for PACES to seek medical attention for my child, _____, in the event of an emergency if I cannot be reached, and to hold harmless and release PACES and PACES from all liability. I further agree to keep the facility informed of changes in telephone numbers, etc., where I can be reached.

Parent's signature _____ Date: _____

PACES emergency medical procedure will be:

1. Contact parent
2. Contact person listed as emergency contact
3. Call emergency medical team, if necessary
4. Have emergency medical team transport to nearest hospital
5. Will seek medical attention from:

Doctor: *The doctor on call from the hospital, and the phone number of the hospital stated below:*

Hospital the center uses: **Cone Health Med Center, 2630 Willard Dairy Rd., High Point, NC 27265**

Revised January 2013