

JSU CHILD DEVELOPMENT CENTER at McCLELLAN

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Mother/Legal Guardian's Name _____

Work # _____ Home # _____

Cell # _____ Beeper # _____

Father/Legal Guardian's Name _____

Work # _____ Home # _____

Cell # _____ Beeper # _____

Child's primary source of health care is

Physician/ Clinic Name Telephone

Known special needs and/or medical conditions (i.e., Diabetes, Asthma, Drug Allergies, Seizures):

Current prescribed medication: _____

In the event of an emergency involving my child, and if _____

(Name of Facility)

_____ cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of the child.

Child's Name _____

Signature (Parent/Guardian) _____ Date _____

Witnessed by _____ Date _____