EMERGENCY AND IDENTIFICATION INFORMATION

FAMILY INFORMATION

Child's Name_____ Date of Birth_____

Child's Home Address_____

Parent/ Guardian_____ Home Phone_____

Place of Employment_____ Work Phone_____

Email Address_____ Cell Phone/Pager_____

Parent/Guardian_____ Home Phone_____

Place of Employment_____ Work Phone_____

Email Address_____ Cell Phone/Pager_____

PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

*Put in order of priority of who should be called to pick up a sick/injured child when parents cannot be reached. Any person listed below has the authority to pick up all children in the family unless an exception is requested in writing by the parent. Updates will be made to all siblings' emergency forms based on the information provided here. Reminder: Information submitted on prior emergency cards will no longer be valid.

Name	Address	Phone	Relationship

CONSENT FOR MEDICAL TREATMENT

AS THE PARENT, AGENCY REPRESENTATIVE OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO THE STAFF OF THE ASSOCIATED STUDENTS SDSU CHILDREN'S CENTER TO PROVIDE ALL EMERGENCY DENTAL OR MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR _____.

NAME OF CHILD

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF MY DEPENDENT. CHILD HAS THE FOLLOWING MEDICATION/FOOD ALLERGIES:

_____

_____

_____ _____

DATE PARENT/AGENCY REPRESENTATIVE/GUARDIAN SIGNATURE

MEDICAL INFORMATION

Physician's Name_____ Phone_____

Dentist's Name_____ Phone_____

Insurance Carrier_____ Policy #_____