EMERGENCY CONTACT FORM

Child's Name _____ Birth Date _____
Last First

Child's Home Address _____
Street/Apt. # City State

Parent/Guardian/Caregivers	Relationship	Phone Number(s)	
		C:	H:
		C:	H:

Child's Physician _____Telephone _____

Address _____
Street/Apt. # City State Zip Code

Preferred Hospital _____Telephone _____

Address _____
Street/Apt. # City State Zip Code

Medical Condition(s):

_____

_____

Medications currently being taken by your child:

_____

_____

Allergies/Reactions:

_____

_____

Additional Comments to Medical Personnel:

_____

_____

_____

_____

In the event of emergencies necessitating immediate medical attention, your child will be promptly transported to the nearest hospital emergency room. Your signature authorizes the CASA Advocate to facilitate the transportation of your child to that hospital.

Signature of Parent/Guardian/Caregiver: _____ Date: _____