Emergency Transportation Form

Child's Name	Mother's Name	Father's Name
Home Address	Home Address	Home Address
City, State, Zip	City, State, Zip	City, State, Zip
Phone:	Phone:	Phone:
If not at home or work, please give us a number where you can be reached if different then above. (Hm./ Wrk./ Cell/ Pager)	Employer's Name	Employer's Name
	Employer's Street Address	Employer's Street Address
Mother:	City, State, Zip	City, State, Zip
Father:	Phone:	Phone:

List two people who can be contacted in an emergency if the parent can not be reached:

Name		Name:	
Address		Address:	
Relationship to Child:	Phone:	Relationship to Child:	Phone:

Name of Physician or Clinic:		Name of Dentist or Clinic:	
Address:		Address:	
City, State, Zip	Phone:	City, Sate, Zip	Phone:

Either Part 1 or Part 2 below must be completed. Do not complete both.

The form only authorizes the childcare center to secure emergency transportation for a child. This form does not authorize or guarantee treatment upon arrival at the designated source of emergency medical or dental treatment, as each emergency facility sets their own treatment procedures.

Part 1. Permission To Transport Child

I give _____my permission to transport my child _____
(name of day care facility) (name of child)
to _____for emergency medical care or to _____ for emergency
(hospital or clinic) (dentist, dental clinic)
dental care, or the nearest available source of assistance.

Parent's Signature:	Date:

Part 2. Refusal To Grant Permission

I do not give permission to _____ to transport my child _____
(name of childcare facility) (name of child)
for emergency medical or dental care. In the event of an illness or injury which requires emergency or dental treatment, I wish the following action to be taken _____

Parent's Signature:	Date:

Health Record Form

Please understand that all information given on this form will only be shared with necessary children's workers and church staff. No child will be discriminated against due to health/medical problems. This information is to assist us in providing your child with the care that they need and to help us insure their safety.

_____

Child's Name **DOB**

1. List all allergies and any special precautions and treatment indicated for these allergies: (foods, medications, or environmental allergies)
   _____
   _____

2. List medication: food supplements, modified diets, or flouride supplements that would effect a child in case of field trip or overnight event:
   _____
   _____

3. List any chronic physical problems which might effect participation:
   _____

Healthcare Plan (to be completed if your child needs specific medical attention:

Condition: _____
Symptoms to watch for: _____
Conditions to avoid that may cause symptoms:
_____

What actions should be taken for these symptoms? (Please be specific)
_____
_____
_____

Are there any medications required? No_____ Yes_____
If so, please explain:
_____
_____

Who provides medical service to your child? _____
Should they be contacted in the event that emergency contacts cannot be reached?
No _____ Yes _____ (Contact Number:_____)

Parent Signature/Date:_____