



# EMERGENCY INFORMATION

Parent Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Alternate Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ Cell: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

DOCTOR'S NAME: \_\_\_\_\_ Phone: \_\_\_\_\_

If emergency treatment is required and the parent or alternate contact cannot be reached, may the VILLAGE OF JEFFERSON authorities use their own judgment in sending your child to the hospital or doctor most easily accessible? YES \_\_\_\_\_ NO \_\_\_\_\_

Does your hospital/physician have permission to administer necessary emergency treatment at the time for your child's safety and well-being? YES \_\_\_\_\_ NO \_\_\_\_\_

If you checked "NO" to either of the questions above, please write specific instructions below for the staff to follow if the parent or alternate contact cannot be reached.

\_\_\_\_\_  
\_\_\_\_\_

\*\*\* PARTICIPANTS MUST PROVIDE HIS/HER OWN INSURANCE \*\*\*

## CHILD PICK-UP INFORMATION

The following people have my permission to pick-up my child:

	NAME	ADDRESS	PHONE	RELATION
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

SIGNATURE: \_\_\_\_\_

Parent or Guardian

DATE: \_\_\_\_\_