

STRETCH THE IMAGINATION

CONTACT AND EMERGENCY MEDICAL RELEASE

Date: _____

Child's Full Name: _____

Birth Date: _____

Home Address: _____

City: _____ Zipcode _____

Parent's Name: _____

Company Name: _____

Work Phone #: _____

Work Address: _____

City: _____

Email: _____

Cellular: _____ Home Phone #: _____

Parent's Name: _____

Company Name _____

Work Phone #: _____

Work Address: _____

City: _____

Email: _____

Cellular#: _____ Home Phone #: _____

If parents live separately, note second parent's address and phone number.

Home Address _____

PERSONS AUTHORIZED TO TAKE CHILD FROM CENTER

Identification will be asked for at the time of pick-up. If you wish to include photographs of authorized persons, please do so.

Parent: _____ Parent _____

Those other than parents who are authorized to pick up your child:

Name: _____ Cell#: _____ Work#: _____

Address: _____

Name: _____ Cell#: _____ Work#: _____

Address: _____

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MEDICAL AUTHORIZATION FORM

CHILD'S FULL NAME:

INSURANCE COVERAGE & NUMBER:

DOCTOR NAME/ADDRESS/PHONE:

LIST ALL ALLERGIES/HEALTH PROBLEMS/NEEDED MEDICATIONS:

AUTHORIZATION FOR MEDICAL TREATMENT

As my child's legal guardian, I hereby give Stretch the Imagination and the employees thereof, permission to obtain medical treatment for my child_____.

I am responsible for the payment of such medical treatment. I authorize personal information needed for the treatment of my child to be released to medical/hospital personnel.

FOR MEDICAL AUTHORIZATION, SIGN HERE:

Parent/Legal Guardian :

_____ Date: _____

Print Name:
