West Forsyth Christian Preschool
Learn. Pray. Play.

Before/After Care Emergency Medical Emergency Release Information

Child's Information:

Child's Full Name_____Home Address:_____

Child's Physician_____

Physician's Address_____Phone_____

Authorized Adults:

In the event of an emergency, please list the names and numbers of both parents/guardians and two other authorized people. These numbers must be daytime numbers during WFCP operating hours.

Father's Name_____ Work Phone_____

Cell Phone_____ Home Phone_____

Mother's Name_____ Work Phone_____

Cell Phone_____ Home Phone_____

Alternate Name _____ Work Phone_____

Cell Phone_____ Home Phone_____

Alternate Name_____ Work Phone_____

Cell Phone_____ Home Phone_____

First Aid, Emergency Care & Health Records Transfer

In the event of an emergency in which I/we cannot be reached or the above listed physician cannot be reached, I/we hereby authorize the staff of West Forsyth Christian Preschool to provide any emergency treatment deemed necessary for the life and health of my/our child. I/we understand that first aid may be needed and authorize the staff of West Forsyth Christian Preschool to provide necessary first aid.

In the event of an emergency, I/we hereby authorize the transfer of my/our child's health records to the local hospital.

Child's Date of Birth_____ Known Allergies_____

Special Medical Instructions_____

Hospital Preference In Case Of Emergency_____

Health Insurance Company_____Policy#_____

Mother's Signature_____Date_____

Father's Signature_____Date_____