Lighthouse Daycare
Emergency Medical Form

Child's Full Name: ___________________________________ Date of Birth: _______________

Father's Full Name: ____

Address: ____

Home Phone: __________ Work Phone: __________ Cell Phone: __________ Beeper: ___________

Employer ____

Mother's Full Name: ____

Address: ____

Home Phone: __________ Work Phone: __________ Cell Phone: __________ Beeper: ___________

Employer ____

Does the child have any type of allergies? ____________ yes ____________ no

If yes, please explain____

Does the child have any type of medical conditions? ____________ yes ____________ no

If yes, please explain____

Child's Physician's Name: ______________________________ Phone: ____________

Address of Physician: ____

Child's Dentist Name: _________________________________ Phone: ____________

Address of Dentist: ____

Are the Child's immunizations up to date? _____ yes _____ no (Provide copy of immunization record)

Medical Insurance Company ___________________________________

Policy Number: ____

Person to contact in case of illness, **IF PARENTS CANNOT BE REACHED:**

1) Name:_______________________________ Phone: ____________ Cell Phone: _________________

Address:____

____

2) Name: _____________________________ Phone: ____________ Cell Phone____________________

Address:____

____

3) Name: ______________________________ Phone: ____________ Cell Phone__________________

Address____

____

I, _________________________________, parent of ______________________________,
(Parent/guardian) (Name of child)
do hereby give my permission and/or consent for Lighthouse Daycare Center to secure and authorize such emergency medical care and/or treatment as my child, named above, might require while under the supervision of the said program. I also agree to pay the entire costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this content.

____ _______________
Parent/guardian signature Date