Keswick
CHRISTIAN SCHOOL

EMERGENCY MEDICAL RELEASE (PRESCHOOL)

Child's Full Name: ______________________________ Birthdate: ______________
Allergies: ______________________________
Medicines Routinely Taken: ______________________________
____

Name of Custodial Parent(s)/Legal Guardian(s): ______________________________
Address: ______________________________ ______________ ________ ________
Street Address (number, apt. #, street) City State Zip Code

MOM Home Phone (___) ____________ Cell Phone (___) ____________ Work Phone (__) ____________
DAD Home Phone (___) ____________ Cell Phone (___) ____________ Work Phone (__) ____________

Physician's Name: ______________________________ Phone (___) ______________
Address: ______________________________ ______________ ________ ________
Street Address (number, apt. #, street) City State Zip Code

Dentist's Name: ______________________________ Phone (___) ______________
Address: ______________________________ ______________ ________ ________
Street Address (number, apt. #, street) City State Zip Code

Hospital Preference: ______________________________
Name City

Medical Insurance Company Name: ______________________________
Policy #: ______________________________ Expiration Date: ______________

Emergency Contact #1: (if parent/guardian cannot be reached)**:** ______________ ______________
Name Relationship to Child
Address: ______________________________ ______________ ________ ________
Street Address (number, apt. #, street) City State Zip Code
Home Phone (___) ____________ Cell Phone (___) ____________ Work Phone (__) ____________

Emergency Contact #2: (if parent/guardian cannot be reached)**:** ______________ ______________
Name Relationship to Child
Address: ______________________________ ______________ ________ ________
Street Address (number, apt. #, street) City State Zip Code
Home Phone (___) ____________ Cell Phone (___) ____________ Work Phone (__) ____________

SIGN IN PRESENCE OF NOTARY

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child ______________________________, in the event of an emergency at which time I cannot be reached. I
(Child's Full Name)
give consent to transport by ambulance if situation warrants. ______________________________
Signature of Custodial Parent/Legal Guardian (Affiant)

STATE OF FLORIDA, COUNTY OF ______________________
The foregoing instrument was acknowledged before me on ______________ ____________ 20______
(Month) (Day) (Year)
by ______________________________, who is personally known to me or who has produced
(PRINT Name of Affiant)
______________________________ as identification.
(Type of identification)

SEAL OF NOTARY

Signed: ______________________________
(Signature of Notary)