EMERGENCY CHILD RECORD

Child's Name: _____ Birthdate__/__/__

Mother: _____ Father: _____

Home Address: _____ Home Address: _____

Mailing Address: _____ Mailing Address: _____

Home Phone:_____Work _____ Home Phone:_____Work _____

Work Location: _____ Work Location:_____

Child's Medical Care Source: Name _____Address _____Phone: _____

Medication or treatment required by child: _____

Allergies (foods, drugs) _____Special dietary needs: _____

Emergency contacts: Name, address and phone of person(s) who can take responsibility for the child if parent can't be reach in an emergency

_____

_____

Siblings enrolled with Island Summer Adventures or Sonshine Preschool: _____

Person(s) authorized to pick child up from camp_____

Signature of parent or guardian_____Date: ____/____/_____

(Use of this portion of the form is optional)

CONSENT FOR EMERGENCY MEDICAL OR SURGICAL CARE

This authorizes KBM Summer Day Camp Staff Director/Associate Directors or KBM Executive Director to give permission to medical or hospital personnel to provide emergency medical or surgical care for **(Child's Name)**_____if I cannot be contacted immediately. I understand that a conscientious effort will be made to locate me or my child's other parent or guardian before any action is taken. I understand my obligation to keep my child care provider informed of my whereabouts. I will assume the cost of necessary medical or surgical care.

_____ _____

Signature of witness Date Signature of Parent or Guardian Date

_____ _____

Signature of witness Date Expiration Date