

Altoona Elementary Lakeshore CV Montessori Roosevelt Sherman

Camp Only

Emergency Card

Child's Name _____ Sex _____

Address _____ Birthdate _____

_____ Home Phone _____

Emergency Contact (Please include parent)

| Name | Phone (Home/Work) | Relationship to Child |
|------|-------------------|-----------------------|
|------|-------------------|-----------------------|

| | | |
|-------|-------|-----------------|
| _____ | _____ | Parent/Guardian |
|-------|-------|-----------------|

| | | |
|-------|-------|-----------------|
| _____ | _____ | Parent/Guardian |
|-------|-------|-----------------|

(continue on back)

Doctor _____ Phone _____

Clinic _____ Hospital Choice _____

Allergies _____

Has your child ever been stung by a bee? Yes No

I hereby give my consent for emergency medical care treatment, to be used only if I cannot be reached immediately.

Parent Confirmation _____ Date _____

