EMERGENCY CONTACT INFORMATION

CHILD'S INFORMATION:

Name: _____ DOB: _____ SSN: _____

Primary Address: _____

Primary Care Physician: _____ Phone:_____

PCP Address: _____

Insurance Name (required): _____ ID No. (required): _____

School District Child lives in: _____

Dentist Name: _____ Phone: _____

Dental Insurance Carrier: _____ ID No.: _____

Once Upon A Time is authorized to provide minor first aid treatment and to obtain emergency transportation to and/or emergency medical care for the above listed child at the nearest hospital's emergency room, or at the emergency room the EMS/Ambulance Service is required to transport patients to at the time of emergency.

_____ Date:_____

Family Member's/Guardian's Signature

Special Needs: □ Yes □ No Allergies: □ Yes □ No Medication: □ Yes □ No

If yes, please attach a separate sheet of paper for additional Medical Professional information as necessary due to your child's unique medical needs.

FAMILY MEMBER'S/GUARDIAN'S INFORMATION:

Name: _____ Email: _____

Home Address: _____

Employer Name: _____Phone: _____

Employer Address: _____

Work Schedule: Days & Hrs: _____

Home Phone: _____ Cell Phone: _____

FAMILY MEMBER'S /GUARDIAN'S INFORMATION:

Name: _____ Email: _____

Home Address: _____

Employer Name: _____Phone: _____

Employer Address: _____

Work Schedule: Days & Hrs: _____

Home Phone: _____ Cell Phone: _____