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2024 - 2025
Medical Emergency Form
(*Please Print Clearly*)

Child's Name _____ Date of Birth _____
(First) (M.I.) (Last)

Address _____
(Street) (City) (State) (Zip)

Pre-existing medical conditions: _____

Home Tel. # (_____) _____

Mom Cell # (_____) _____ Dad Cell # (_____)_____

Parents' Names: Mom _____ Dad_____

Physician's Name _____Telephone # (_____)_____

Insurance Carrier _____ Policy # _____

People to call if a parent cannot be reached:

1. _____Telephone # (_____)_____

2. _____Telephone # (_____)_____

In the event I cannot be reached, I hereby authorize the First Pres. Nursery School Director or Teacher in Charge to have my child transported to a hospital for emergency treatment. I give my permission to the hospital and/or my child's Pediatrician to provide emergency medical treatment for my son/daughter. Medical personnel are granted consent to carry out required emergency treatment for my son/daughter. I understand that I am responsible for all medical costs incurred with regard to examinations and medical services rendered.

_____ _____
Parent or Legal Guardian Signature Date