Emergency Medical Card

Child_____ DOB:_____

Address: _____ City: _____, IN Zip: _____

Parent/Guardian: _____ Emergency #: _____

Parent/Guardian: _____ Emergency #: _____

Emergency Contact Name: _____ Relationship: _____ Emergency #: _____

Pediatrician: _____ Ph: _____

Address: _____

Preferred Hospital and location: _____

Dentist: _____ Ph: _____

Address: _____

Medications your child is currently taking: _____

Allergies or special medical problems/needs: _____

Consent to hospitalization, surgery, or other medical treatment during parent's/guardian's absence:

I, _____ (parent/guardian), authorize Speedway Cooperative Preschool to consent to all necessary medical and/or surgical treatment in my absence for _____ (child).

Parent/Guardian Signature: _____

Pickup Authorization List

Class: _____

Child's Name: _____

Parent/Guardian: _____

Parent/Guardian: _____

Please list below those people authorized to pick up your child. If possible, please list at least one co-op member who is in the same class as your child:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Parent/Guardian Signature: _____

Please list below those people who are NOT authorized to pick up your children:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Parent/Guardian Signature: _____