South Hackensack Memorial School

PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

Name Of Child:	Birthdate:	Enrollment Date:

PARENT/GUARDIAN INFORMATION

	☐ PARENT/GUARDIAN # 1		☐ PARENT/GUARDIAN # 2
Name:		Name:	
Relationship:		Relationship:	
Cell Phone:		Cell Phone:	
Home Phone:		Home Phone:	
Home Address:		Home Address :	
Employer Name:		Employer Name:	
Employer Phone:		Employer Phone:	
E-Mail Address:		E-Mail Address:	

EMERGENCY CONTACTS

Persons authorized to pick up your child and/or contact in case of emergency if neither parent is available to assume responsibility for the child.

Contact Name #1:		Contact Name #2:		Contact Name #3:	
Relationship:		Relationship:		Relationship:	
Cell Phone:		Cell Phone:		Cell Phone:	
Home Phone:		Home Phone:		Home Phone:	
Employer Phone:		Employer Phone:		Employer Phone:	

CUSTODY

Name of person PROHIBITED from picking up your child:	

If a non-custodial parent has been denied access, or granted limited access, to the child by a court order, please submit documentation to this effect for the center to maintain a copy on file, and to comply with the terms of the court order.

MEDICAL INFORMATION

Child's Health Care Provider:	
Health Care Provider Phone:	
Health Care Provider Address:	
Name Of Insurance Company/Hmo:	
Group #:	
Identification #:	
Subscriber's Name On Insurance Card:	
Known Allergies (including medication):	
Medication My Child Is Taking:	
List Special Conditions, Disabilities, Medical/Physical Restrictions, Medical Information For Emergency Situations:	

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

As the parent(s)/ legal guardian(s) of the above named child, I (we) attest that the information above is correct. I (we) authorize the child care center staff to obtain emergency treatment for my child and understand that I (we) shall be promptly notified.

Parent/Guardian Signature #1:	Date:	Parent/Guardian Signature #2:	Date: