Longwood Medical Area Child Care Center

EMERGENCY CARD INFORMATION

Child's Name: _____
Date of Birth: _____

Child's Home Address: _____
Phone: _____

INSTRUCTIONS TO REACH PARENT/GUARDIAN

1. _____
(Name, Address, Phone #)

2. _____
(Name, Address, Phone #)

PEDIATRICIAN OR SOURCE OF HEALTH CARE

1. _____
(Doctor's Name, Address, Phone #)

EMERGENCY CONTACT PERSON(S)

1. _____
(Name, Address, Phone #)

2. _____
(Name, Address, Phone #)

MEDICAL EMERGENCY TREATMENT

I hereby give _____
(Name of program)
Permission to administer basic first aid and/or CPR to my child
_____ and/or take my child _____ ,
(Name) (Name)
to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

_____ _____
(Parent Signature) (Date)

395 Longwood Avenue, Boston, MA 02215 • Telephone: 617-632-2755 Fax: 617-632-2724
Email: kquinn@masco.harvard.edu

INSURANCE INFORMATION (OPTIONAL)

Company Name: _____ Policy # _____

Participating Hospital: _____

Special Instructions:

_____

_____

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