CKC, INC. EMERGENCY INFORMATION

School Year _____

Child's Name _____ Date of Birth _____

Mother's Name _____ Mother's Telephone _____

Mother's Address _____ Mother's Cell Phone _____

Father's Name _____ Father's Telephone _____

Father's Address _____ Father's Cell Phone _____

Mother Employed by _____ Mother's Work Telephone _____

Father's Employed by _____ Father's Work Telephone _____

Other persons that can be contacted in the event of an emergency:
Child will not be allowed to leave with any other person without written authorization of parent/guardian.

	Name	Relationship	Telephone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Pediatrician _____ Address _____ Phone _____

Dentist _____ Address _____ Phone _____

Allergies:
Medications _____
Pollen _____
Hayfever _____
Food _____
Other _____

Medical Conditions:
Chronic Illness _____
Asthma _____
Convulsions _____
Diabetes _____
Other_____

Please Explain _____

_____

_____

Insurance Company Name and Policy Number _____

Consent for Medical/Dental Treatment:
As the parent, agency representative, or legal guardian, I hereby give consent to Campus Kids Connection, Inc. to provide all emergency dental or medical care prescribed by a duly licensed physician (MD) or dentist (DDS) for my child. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

_____ _____
Signature of Parent or Guardian Date