McGINNIS WOODS
Country Day School

EMERGENCY MEDICAL INFORMATION
(please print)

Child's Name:_____Home Phone:_____

Father's Name:_____

Work Phone:_____ Cell Phone:_____

Mother's Name:_____

Work Phone:_____ Cell Phone:_____

Child's Physician:_____ Office Phone:_____

Physician's Address:_____

Allergies:_____
*****All food allergies require written documentation from a physician.

Special Medical Needs:_____

Daily Prescribed Medications:_____

Emergency Medical Facility: **EMORY JOHNS CREEK HOSPITAL**
6325 WEST JOHNS CROSSING
SUWANEE, GEORGIA 30097
(678) 474-7000

(OR THE CLOSEST EMERGENCY MEDICAL FACILITY AT THE TIME OF THE INCIDENT)

I believe the above information to be true and correct. It is my responsibility, as the child's parent/guardian to immediately update this form if any information should change.

We hereby grant McGINNIS WOODS COUNTRY DAY SCHOOL permission to take whatever action in its judgment that may be necessary in supplying emergency medical services to the above named child. We hereby agree that we will be solely responsible for and will promptly pay any expenses which may be incurred by McGINNIS WOODS COUNTRY DAY SCHOOL in making emergency medical treatment, including emergency transportation, available to the above named child.

_____ _____
(Parent's signature) **(Date)**

**** PLEASE FILL IN ALL BLANKS ****

12/08