EMERGENCY MEDICAL INFORMATION

ALL BLANKS MUST BE COMPLETED

PLEASE PRINT. ONE CHILD PER FORM ONLY

Child's Last Name: _____ Child's First Name: _____

Date of Birth: _____ 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.**

- ❑ No Allergies

Special Medical Needs/conditions:

- ❑ Asthma
- ❑ Other: _____
- ❑ No Special Medical Needs/conditions

Daily Prescribed Medications:

_____

- ❑ No Daily Prescribed Medications

EMERGENCY MEDICAL FACILITY:

EMORY JOHNS CREEK HOSPITAL (OR THE CLOSEST EMERGENCY MEDICAL FACILITY AT THE TIME OF THE INCIDENT)
6325 HOSPITAL PARKWAY
JOHNS CREEK, GEORGIA 30097

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 judgement 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 incurred by MCGINNIS WOODS COUNTRY DAY SCHOOL in making emergency medical treatment available to the above-named child.

_____

PARENT'S SIGNATURE DATE