THE HEIGHTS CHILD DEVELOPMENT CENTER

EMERGENCY MEDICAL INFORMATION AND AUTHORIZATIONS

CHILD'S NAME _____ _____ _____ _____
(Last) (First) (Middle) (Name Called)

DATE OF BIRTH_____ **ALLERGIES:**_____
(Month/Day/Year) (Please complete allergy information sheet on back side of form)

PARENT / GUARDIAN NAME(S) _____

PARENT / GUARDIAN PHONE NUMBER(S) _____

PARENT / GUARDIAN EMAIL ADDRESS(ES) _____

EMERGENCY CONTACTS

Emergency Contacts are someone *other than the parent/guardian* that can be contacted in the case of an emergency that know medical information regarding the child. These persons do not have to be local.
(Minimum of 2 contacts with address and phone number required)

Emergency Contact #1 (OTHER THAN PARENT OR GUARDIAN)

Name: _____ Relationship to child: _____

Address: _____

Phone: _____

Emergency Contact #2 (OTHER THAN PARENT OR GUARDIAN)

Name: _____ Relationship to child: _____

Address: _____

Phone: _____

**A child will only be released from The CDC to his/her mother, father, or other persons authorized by the parents. In the case of marital separation, THBC cannot deny either parent access to a child unless copies of legal documentation stating otherwise are provided.

AUTHORIZED PICK-UP PERSONS: (will not be contacted in emergency – this only gives permission to release your child to this person without having to contact the parent/guardian first – must present PHOTO ID)

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

Authorization for Emergency Medical Attention:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to contact the Physician below:

Name of Physician: _____ Address: _____ Phone: _____

And/or the closest emergency medical facility as determined by first responders in the case of a 911 call:
Methodist Richardson Medical Center, 2831 E President George Bush Highway, Richardson, Texas 75080 PH: 469-204-1000

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Parent's Signature: _____ **Date:** _____

THE HEIGHTS CDC RESERVES THE RIGHT TO CALL 911 IN ANY EMERGENCY SITUATION

THE HEIGHTS CHILD DEVELOPMENT CENTER

ALLERGY PLAN FOR DIAGNOSED ALLERGIES

CHILD'S NAME _____ _____ _____ _____
(Last) (First) (Middle) (Name Called)

DATE OF BIRTH_____ **ALLERGIES:**_____
(Month/Day/Year)

Please complete the following form for all MEDICALLY DIAGNOSED allergies.

Allergen: _____

Is the allergy to touch or ingestion: _____

Symptoms *(please describe any known symptoms to the allergen):*

_____

_____

Does your child have an EPI pen? _____ YES _____ NO

_____ If checked, give Epinephrine immediately for any LIKELY ingestion, for ANY symptoms.

_____ If checked, give Epinephrine immediately for any DEFINITE ingestion, even with no symptoms

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Allergen: _____

Is the allergy to touch or ingestion: _____

Symptoms *(please describe any known symptoms to the allergen):*

_____

_____

Does your child have an EPI pen? _____ YES _____NO

_____ If checked, give Epinephrine immediately for any LIKELY ingestion, for ANY symptoms.

_____ If checked, give Epinephrine immediately for any DEFINITE ingestion, even with no symptoms

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_____ _____
PARENT/GUARDIAN SIGNATURE **DATE**

_____ _____
PHYSICIAN SIGNATURE **DATE**