



**WINDSOR CHRISTIAN PRESCHOOL
Emergency Contact/Medical Release**

Child's Name _____ M / F

Date of Birth _____ Home Phone _____

Street Address _____ City _____ Zip _____

Father's Name _____ Work phone _____ Cell phone _____

Mother's Name _____ Work phone _____ Cell phone _____

Allergies, including reactions to medications (**if none, so state**) _____

History of any physical or medical problems _____

Is child on any medications? _____ If so, what and why? _____

Health Insurance Carrier _____ ID # _____

Subscriber _____ Relationship _____

Child's Physician _____ Phone _____

Preferred Hospital _____

In case of illness or emergency and we are unable to contact either parent or guardian, please list two nearby relatives or neighbors we should contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

We, the parents/legal guardians of _____, do hereby authorize the performance upon our child, by any physician licensed to practice medicine in the Commonwealth of Pennsylvania, any emergency procedure the Physician deems necessary to save the life, limb, or continued good health of our child.

Any emergency surgical procedure is to have the unreserved consensus of not less than two (2) licensed physicians. This document is in no way intended for or to be construed as authorization for the performance of any investigational procedure or treatment.

We take full financial responsibility for any emergency procedure or treatment performed.

This document is valid only after any unsuccessful attempt is made to locate the parents or legal guardians of the child noted hereon.

(DOCUMENT MUST BE SIGNED BY BOTH PARENTS)

Parent/Legal Guardian's Signature Date

Parent/Legal Guardian's Signature Date