SLKF AFTER HOURS MASTER CARD

Child's Name: _____ Class: _____

	MOTHER	FATHER
NAME		
ADDRESS		
HOME PHONE #		
WORK PHONE #		
CELL PHONE #		

Person with whom the child lives:

_____

Child's Doctor: _____ Doctor's Phone #: _____

Child's Dentist: _____ Dentist's Phone #: _____

Individuals (other than parents listed above) to contact in case of emergency:

_____ Phone # _____ Relationship: _____
_____ Phone # _____ Relationship: _____
_____ Phone # _____ Relationship: _____

Does your child have any:

	YES	NO	IF YES, PLEASE EXPLAIN
FOOD ALLERGIES			
OTHER ALLERGIES			
DIETARY RESTRICTIONS			
SPECIAL NEEDS/HEALTH CONCERNS			

My child has permission to be released to the following individuals IN ADDITION to parents and emergency contact persons listed above. **PLEASE NOTIFY THESE INDIVIDUALS THAT THEY MUST BRING PROOF OF IDENTIFICATION WHEN PICKING UP YOUR CHILD.**

NAME (First and Last)	RELATIONSHIP

I authorize the facility to secure emergency medical treatment for my child.

_____ _____

Parent's Signature Date