



GROWTH & LEARNING OPPORTUNITIES

EMERGENCY CARD - Side 1 of 2

THIS FORM WILL BE TAKEN WITH YOUR CHILD ON FIELD TRIPS OR OUTINGS. PLEASE COMPLETE **BOTH SIDES**

Please Print Legibly

Child's Last Name	First name	Middle name	GLO Site Child/Youth Attends
Address			Telephone
City	State	Zip Code	Date of Birth

ILLNESS, ACCIDENT OR LEAVING PROGRAM PREMISES: In the event of illness or accident, when I cannot be reached, I wish one of the following to be notified by telephone. They are authorized to act in my absence. They may also release my child from the program.

Name	Address	Daytime Telephone
Name	Address	Daytime Telephone

DOCTOR'S NAME AND TELEPHONE: In case of emergency I wish the following doctors to be notified:

Doctor 1	Telephone 1	Doctor 2	Telephone 2
Special Instructions			

PARENT/GUARDIAN DAYTIME TELEPHONE: The following telephone numbers may be used in cases of emergency:

Parent/Guardian One Name	Relationship	Daytime Telephone
Parent/Guardian Two Name	Relationship	Daytime Telephone

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CONSENT FOR MEDICAL TREATMENT - Side 2 of 2

AS THE PARENT, AGENCY REPRESENTATIVE OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO

_____ TO PROVIDE ALL EMERGENCY DENTAL OR MEDICAL
CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR
FACILITY NAME

_____ THIS CARE MAY BE GIVEN UNDER WHATEVER CON-
DITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF MY DEPENDANT.
CHILD'S/YOUTH'S NAME

CHILD/YOUTH HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT/AGENCY REPRESENTATIVE/GUARDIAN SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE	CELL PHONE
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EMAIL ADDRESS