MASTER CARD

Child's Name: _____ Sex _____ D.O.B _____

	MOTHER	FATHER
NAME		
ADDRESS		
EMPLOYER		
HOME PHONE #		
CELLULAR PHONE #		
BEEPER #		

Person with whom child lives: _____

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

Individuals to contact in case of an emergency:

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

Does your child have any food allergies? Yes No
Does your child have any other allergies? Yes No
Does your child have any dietary restrictions? Yes No
Please explain any yes answer here: _____

My child has permission to be released to the following individuals, child care facilities, or transportation services in addition to emergency contact persons listed above.

(Please notify these individuals that they may be asked to show proof of identity.)

NAME	RELATIONSHIP

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

Parent's Signature: _____ Date: _____

Date of Admission: _____