

Application Forms



# Emergency Medical Consent Form

Drool of Rock and it's instructors have permission to obtain emergency medical treatment for my child \_\_\_\_\_ when I can't be reached or if a delay in reaching my child would be dangerous for him/her.

Mother/Guardian's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Father/Guardian's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Insurance Provider \_\_\_\_\_

Child's Medical Record Number \_\_\_\_\_

Preferred Hospital / Center \_\_\_\_\_

My Child's Medications \_\_\_\_\_

My Child's Allergies \_\_\_\_\_

By checking this box, I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while he/she is in child care at Drool of Rock.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_