In Case of Emergency

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Child’s Name: | | | Nickname: | | | | | Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ | Primary Language/Communication: | | | | | | | |
| Home Address: | | | | | | | | |
| Parents/Guardians: | | | Relationship: | | Phone Number: | | | |
| Parents/Guardians: | | | Relationship: | | Phone Number: | | | |
| Diagnosis: | | | | | | | | |
| Medications: | | Dose: | | | | Time: | | |
|  | |  | | | |  | | |
|  | |  | | | |  | | |
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|  | |  | | | |  | | |
| Allergies: | | | | | | | | |
| Emergency Contact: | | Relationship: | | | | Phone Number: | | |
| Physician Information: | | | | | | | | |
| Doctor Name: | | | | Phone: | | | Fax | |
| Specialist Name: | | | | Phone: | | | Fax: | |
| Specialist Name: | | | | Phone: | | | Fax: | |
| Insurance: | | | | | | | Group: | |
| Hospital Information: | | | | | | | | |
| Name: | | | | | Phone: | | | |
| Address: | | | | | ER Phone: | | | |
| Pharmacy Information: | | | | | | | | |
| Name: | | | | | Phone: | | | |
| Address: | | | | | | | | |
| Other: | | | | | | | | |
| Most Important Things to Know About Me In an Emergency: | | | | | | | | |