

Name of insured _____

Employer of insured _____

Primary health care provider _____ Phone _____

Dental provider _____ Phone _____

The following information will be used to contact those persons who will be responsible for making emergency medical decisions on behalf of the child listed above. Parental or guardian contact information must be updated if/when it changes. ONLY LIST THE NAMES OF THOSE WHO HAVE AUTHORITY TO MAKE DECISION IN AN EMERGENCY SITUATION INVOLVING THIS CHILD. List at least one person who may be contacted in an emergency in the event the parents or guardians are unavailable. Additional persons and their contact information can be listed on the back of this form.

Mother's name _____ Cell _____ Home _____
Last First

Address _____
Street City State Zip

Mother's Employer _____
Name Address Work Phone

Father's name _____ Cell _____ Home _____
Last First

Address _____
Street City State Zip

Father's Employer _____
Name Address Work Phone

ADDITIONAL EMERGENCY CONTACT

Name _____ Cell _____ Home _____
Last First

Address _____
Street/Apt.# City State Zip

Employer _____
Name Address Work Phone

MEDICAL CONDITIONS

Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.

Child's Name _____ Birth Date _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS

(1) Signs/symptoms to look for: _____

(2) If sign/symptoms appear, do this: _____

(3) To prevent incidents: _____

In EMERGENCIES requiring immediate medical attention, your child will be taken to the nearest hospital emergency room. Your signature below authorizes the responsible person at _____ Long Island Abundant Life Church to have your child transported to that hospital. It also authorizes LIALC personnel to contact the child's primary care or dental provider, in the event of an emergency.

I HEREBY GIVE PERMISSION FOR THE THOSE RESPONSIBLE FOR MY CHILD AT LIALC TO AUTHORIZE MEDICAL TREATMENT FOR MY CHILD IN THE EVENT OF AN EMERGENCY.

Signature of Parent/Guardian _____ Date _____

Signature of Parent/Guardian _____ Date _____