EMERGENCY CARE INFORMATION FORM
(CB & HB)
All blanks must be completed

Child: ____ D.O.B. ________ Class/Area # _________

Parents: ____ / ____
(name) (address) (zip)

Parent's Phone # (home) ________________________________ (work) _________________________________

****Best Way to Contact you? (circle) Phone call Text Message Email Other _______________**

Emergency Contact Person ____ ph # _______________________

Physician ____ ph # _______________________

Dentist ____ ph # _______________________

Hospital ____ ph # _______________________

Ambulance #_______________________________________ Police # _____________________________

Medical Alerts: ____
(must be the same as *Medical Alert* Form)

Medication Allergy: ____

Other Allergies: ____

I give PACT consent for the following items marked "yes":

Yes ___ No ___ Secure EMERGENCY medical care for my child when I/we cannot be immediately reached at the time of emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement. The preferred doctor/clinic/hospital is listed above.

Foster ____ ☐ *

Yes ___ No ___ To administer prescribed medicine to my child as specified in written instructions on *Medication* form.

Yes ___ No ___ To administer patent medicine to my child as specified in written instructions on *Medication* form AND a written, signed statement from a physician.

Signature parent/guardian ____ Date__________________

*** ___ *Foster Child - no signature needed for this item. Must call DCFS Acting Agent at time treatment is needed.***
ph # ____

FA: Distributes copies:
____ Bus Driver ____ Family Advocate ____ Site Supervisor (DCFS file) _____ Emails to Health Coordinator
Original to Teacher for H & S Notebook ____ Teacher File