



TYSONS CORNER CHILDREN'S CENTER  
**EMERGENCY CARD & AUTHORIZATION FOR EMERGENCY TREATMENT**

Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Date of Entry \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Employer \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Employer \_\_\_\_\_

Designated phone contact in case of injury \_\_\_\_\_  
Child's physician or source of health care \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Child's dentist \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Any known allergies? \_\_\_\_\_ Reaction \_\_\_\_\_  
Action to be taken \_\_\_\_\_  
Medicines child is taking? \_\_\_\_\_  
Hospitalization or medical conditions \_\_\_\_\_

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**Emergency Contact Other Than Parent**

1. Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

2. Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

3. Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Persons authorized to pick up child \_\_\_\_\_  
Persons **not authorized** to pick up child \_\_\_\_\_  
Parents marital status  Married  Single/Separated  Divorced  
Who has legal custody of this child? \_\_\_\_\_

The \_\_\_\_\_ Center has my permission, in the event that there is an immediate medical emergency or situation in which medical care must be administered to my child, when I (or my physician) cannot be contacted, to take my child to the emergency room of the nearest hospital, and the hospital and its medical staff have my authorization to provide treatment which a physician deem necessary (which may include agreements for the administration of anesthesia) to provide necessary treatment for my child. The parent is responsible for payment of medical expenses.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Insurance Company \_\_\_\_\_ ID/Policy No. \_\_\_\_\_