Casa dei Bambini School Inc.

Identification and Emergency Information

Child's name: Last	Middle	First		
Home Address: Number	Street	City	State	Zip
Home phone: ( )	Sex Male / Female	Birth date:		

Father's Name: Last	Middle	First		
Home Address: Number	Street	City	State	Zip
Business phone: ( )	Home Phone: ( )	Cell Phone: ( )		

Mother's Name: Last	Middle	First		
Home Address: Number	Street	City	State	Zip
Business phone: ( )	Home Phone: ( )	Cell Phone: ( )		

Person Responsible for child: Last	Middle	First
Business phone: ( )	Home Phone: ( )	Cell Phone: ( )

Additional Persons who may be called in an emergency

Name	Address	Telephone	Relationship

Physician or Dentist to be called in an emergency

Physician's Name	Address
Medical plan AND number	Telephone
Dentist's Name	Address
Dental plan AND number	Telephone

If Physician cannot be reached, what action should be taken?

- ☐ Call emergency hospital
- ☐ Other. Explain: _____

---------- CONSENT FOR MEDICAL TREATMENT ----------

AS THE PARENT, AGENCY REPRESENTATIVE OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO CASA DEI BAMBINI TO PROVIDE ALL EMERGENCY DENTAL OR MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OR DENTIST (D.D.S.) FOR: _____
CHILD'S NAME

THIS CARE MY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF MY DEPENDENT

_____ _____
DATE PARENT/AGENCY REPRESENTATIVE/GUARDIAN SIGNATURE

PARENT/AGENCY REPRESENTATIVE/GUARDIAN PRINTED NAME: _____