Master Card

Child's Name: _____ **Sex:** _____ **Birthdate:** _____

	Mother	Father
Name		
Address		
Employer		
Home Phone #		
Work Phone #		
Cellular Phone #		
Email Address		

Person with whom the child lives: _____

Child's Doctor: _____ Doctor's Phone #: _____

Child's Dentist: _____ Dentist's Phone #: _____

Individuals to contact in case of an emergency:

_____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

Does your child have any food allergies? Yes No

Does your child have any other allergies? Yes No

Does your child have any dietary restrictions? Yes No

Please explain any "yes answer here: _____

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My child has permission to be released to the following individuals in addition to emergency contact persons listed above.

(Please notify these individuals that they may be asked to show proof of identity.)

Name	Relationship

I authorize the facility to secure emergency medical treatment for my child.

Parent's Signature: _____ **Date:** _____