Emergency Contact Card

Child: ________ Sex: ☐ Male ☐ Female

DOB (dd/mm/yy): ________ OHIP # (Optional): ________

Primary Contact #1 ________ Relationship: ________

Home Address: ________

Telephone: H: ________ C: ________ W: ________

E-mail: ________

Primary Contact #2 ________ Relationship: ________

Home Address: ________

Telephone: H: ________ C: ________ W: ________

E-mail: ________

Alternate Contact #1 ________ Relationship: ________

Home Address: ________

Telephone: H: ________ C: ________ W: ________

E-mail: ________

Alternate Contact #2 ________ Relationship: ________

Home Address: ________

Telephone: H: ________ C: ________ W: ________

E-mail: ________

To Whom The Child May Be Released #1 ________ Relationship: ________

Telephone: H: ________ C: ________ W: ________

To Whom The Child May Be Released #2 ________ Relationship: ________

Telephone: H: ________ C: ________ W: ________

Family Doctor or Pediatrician ________ Telephone: ________

Address: ________

Parental Consent for Emergency Treatment

Signature: ________________ Date: ________

Allergies/Medical Conditions	Symptoms	Treatment

(Please sign even if your child has no allergies)

Signature: ________________ Date: ________