

**Green Spring Presbyterian Preschool
Student Medical Plan / ID card**

Program _____

Date _____

Child's Name _____ Age _____ DOB _____
Last First Middle

Address _____ Phone _____

Known Allergies _____

Child's Physician _____ Phone _____

Father/Guardian _____ Mother/Guardian _____

Phone _____ Phone _____

Employer/phone _____ Employer/phone _____

Emergency Contact (other than parent) 1. _____ Phone _____

2. _____ Phone _____

With whom does child reside? _____

Parent's Request in an emergency:

EMERGENCY TREATMENT AUTHORIZATION

Child's Name: _____

In the event of an illness or accident which requires immediate medical treatment or transportation to a medical facility at a time when a parent cannot be located, I give permission for Preschool Director _____, or other church or preschool personnel designated by the director, to authorize such treatment. I understand that in some medical situations, it may be necessary to contact emergency resources before the parents.

Date: _____ Signature: _____

Health Insurance Company: _____ Group No.: _____

Policy Holder: _____ Policy No.: _____