DATA ENTRY FORM/ STUDENT EMERGENCY CARD

Child Information
Full Name: ____________________ Gender**:** _______ Birth Date**:** _________
Enrollment Date**:** _____________

Primary (Enrolling) Guardian

Full Name:_______________________Gender:____Birth Date:______________
Address____
City:___________________State:_____Zip Code:_________County__________
Employer:____Hours:__________
Employer Address____
City:___________________State:_____Zip Code:_________County:_________
Phone:_______________________Work Phone:__________________________
Email:____

Secondary Guardian

Full Name:_______________________Gender:____Birth Date:______________
Address____
City:___________________State:_____Zip Code:_________County__________
Employer:____Hours:__________
Employer Address____
City:___________________State:_____Zip Code:_________County:_________
Phone:_______________________Work Phone:__________________________
Email:____

Authorized People for Pick- up and Emergency Contact Listed in Order of Priority:

Full Name:____
Relation to child: _____________________ Emergency Contact YES NO
Authorized to pick up child from child care YES NO
Address: ____
City: __________________ State:___________ Zip:______________
Phone Numbers(s):____

Full Name:____
Relation to child: _____________________ Emergency Contact YES NO
Authorized to pick up child from child care YES NO
Address: ____
City: __________________ State:___________ Zip:______________
Phone Numbers(s):____

Full Name:____
Relation to child: _____________________ Emergency Contact YES NO
Authorized to pick up child from child care YES NO
Address: ____
City: __________________ State:___________ Zip:______________
Phone Numbers(s):____

Physician Information

Name: ____

Address: ____

City: ______________________ State:___________ Zip:_____________

Phone: (_____) ______-_____________ Ext.___________

Please note, if no physician is listed, we will contact Children's Health Care in case of emergency

Dentist Information

Name: ____

Address: ____

City: ______________________ State:___________ Zip:____________

Phone: (_____) ______-_____________ Ext.___________

Please note, if no Dentist is listed, we will contact Children's Dental Care in case of emergency

Allergies:____

____

____

Medical Concerns: ____

____

____

Is your child currently taking any medications? Yes _____ No_____ If yes, please list: ____

____

____

Margaret Mary Health

Batesville, INDIANA

I (We) the undersigned parents, or legal guardians of (name of child) ______________________________, a minor, authorize treatment of my (our) child by a licensed medical physician on staff at Margaret Mary Health and or any hospitalization that is necessary in case of an accident or illness. This consent form will remain effective until revoked in writing by the undersigned.

Blood Type, Surgical History and Date of Last Tetanus:

____

____

Insurance Company:____

Policy Number: ____

I (We) understand that this consent authorization is given in advance of any specific diagnosis or hospital care being required in order to provide authority to Margaret Mary Health to render and all diagnosis, treatment, or hospital care deemed advisable by the physician attending the child in case of an accident or injury.

AUTHORIZATION SIGNATURE

Father____Date___________

Mother____Witness________