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	Symptoms	Treatment

(Please sign even if your child has no allergies)

Signature: ______ Date: ______