Sonshine Christian Elementary, Daycare and Preschool

MEDICAL AND EMERGENCY INFORMATION

11208 N.E. Hazel Dell Ave.
Vancouver, WA. 98685
Phone (360) 573-7174
sonshinedaycare@gmail.com
sonshinechristian.org

Personal Information:

Please list persons authorized to pick your child up:

Name and relationship to the child:
Phone #:
Address:

Name and relationship to the child:
Phone #:
Address:

Emergency Contact (other than yourself):

Name and relationship to the child:

Address:

Phone #:

I agree to all the policies laid out in the Sonshine Christian Daycare Parent Handbook.

Parents Signature: _____ Date: _____

Additional Authorized Pick Ups

Name and relationship to the child:
Phone #:
Address:

Name and relationship to the child:
Phone #:
Address:

Name and relationship to the child:
Phone #:
Address:

Name and relationship to the child:
Phone #:
Address:

Name and relationship to the child:
Phone #:
Address:

Name and relationship to the child:
Phone #:
Address:

Limited Power Of Attorney
For
Emergency Medical Care Authorization

For: _____
(First Name) (Middle name) (Last name)

I _____(natural parent or legal guardian) hereby give permission that my child _____, may be given emergency treatment to include first aid and CPR by a qualified child care staff member at Sonshine Christian Daycare and Preschool. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by my child's regular physician, or when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I accept all financial responsibility for necessary treatment and services.

Primary phone number:
Home address:

Insurance Company: _____

Plan or Group Number: _____ Policy/Membership # _____

Employer: _____
(Name of Company) (Phone)

_____
(Address of Employer)

Allergies: _____

Other: _____

Signature: _____

Relationship to Student: _____

Date: _____