Canfield Little Cardinals Emergency Contact and Medical Information

Child's Name		Date of Birth M/F TEAM	
Parent's/Guardian's Name		Parent's/Guardian's Name	
Primary Phone	Secondary Phone	Primary Phone	Secondary Phone
Address		Address	
City, ST ZIP Code		City, ST ZIP Code	
Alternative Emergency Contact		Phone	

Treatment Permission

I hereby give my consent permitting CLC personnel to apply first aid treatment to my child until the family doctor can be contacted. **Y/N**

In the event the designated practitioner is not available, I hereby give my consent for the CLC to secure another licensed physician/dentist. **Y/N**

I hereby give my consent to the CLC personnel to secure ambulance service and transfer of my child to preferred hospital or any hospital reasonable accessible. **Y/N**

Note: This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to performance of such surgery.

Medical Information

Hospital/Clinic Preference	
Physician's Name	Phone Number
Dentist's Name	Phone Number
Allergies/Special Health Considerations	
Parent's/Guardian's Signature	Date