EMERGENCY INFORMATION

Name of Child:_____ DOB_____

Mothers Name: _____ Email: _____

Telephone: (____) _____ (____) _____
Home Cell

Home Address: _____
Street Name and Number Apt. # City Zip Code

Fathers Name: _____ Email: _____

Telephone: (____) _____ (____) _____
Home Cell

Home Address: _____
(If different frrom above) Street Name and Number Apt. # City Zip Code

FOR STAFF USE ONLY:
Date of enrollment: _____

Dental Ins: _____
Policy #: _____

Medical Ins. _____
Policy #: _____

Employment Information

***Mother*:**
Name of Employer: _____ Telephone:_____

Work Address: _____
Street Name and Number City Zip Code

***Father*:**
Name of Employer: _____ Telephone: _____

Work Address: _____
Street Name and Number City Zip Code

Childs Physician: _____ Telephone:_____

Address: _____
Street Name and Number City Zip Code

Dentist:_____ Telephone:_____

Address: _____
Street Name and Number City Zip Code

Authorized to pick up: (full name and phone #)
***May list up to 3 people aside from mother and father. Must be 18 yrs or older and provide a valid ID.**

1._____

2._____

3._____

CONSENT FOR EMERGENCY MEDICAL TREATMENT:

As the parent or authorized representative, I hereby give consent to ISLA VISTA YOUTH PROJECTS to obtain all emergency medical or dental care prescribed by a duly licensed physician (M.D.), dentist (D.D.S.) or osteopath(D.O.) for _____ . This care may be given under whatever conditions are necessary to preserve the life, limb or well being of the child named above. If paramedics advise, the child will be transported to Goleta Valley Cottage Hospital emergency room.

The child has the following allergies: _____

_____ _____
Date **Parent or Authorized Representative Signature**