MEYER CENTER FOR SPECIAL CHILDREN

MEDICAL EMERGENCY AGREEMENT

Child's Name: _____ Date of Birth: _____

In the event of a medical emergency, I/we may be contacted at the following numbers:

	Name	Work Phone	Home Phone	Cell/Beeper
Mother				
Father				
Step-parent				
Legal Guardian				

Other relative(s) or friends who may be contacted in an emergency. (Provide at least one person outside household.)

Name	Relationship	Work Phone	Home Phone	Cell/Beeper

In the event of emergency and none of the above can be contacted immediately, I authorize the Director of the Meyer Center for Special Children, or a person designated responsible for emergencies, to secure emergency medical treatment for my child. I agree to be responsible for the cost of all emergency medical treatment and to hold the Meyer Center for Special Children harmless from all cost and claims as a result thereof. Emergency care will normally be obtained at Greenville Memorial Hospital Emergency Room.

Physician to be Contacted:_____ Phone: _____

Physician Address: _____

_____ _____

Parent/Guardian Signature **Date**

MEDICAL INFORMATION

Diagnosis/Medical Condition _____

Allergies to Foods/Milk _____

If your child cannot eat foods provided by the Meyer Center, please attach a doctor's or nutritionist's note.

Allergies to Medication(s) _____

Other Allergies: _____

Child has: Shunt: ☐ Yes ☐No Feeding Tube: ☐Yes ☐No Seizures: ☐Yes ☐No

Medication(s) Used Regularly_____

_____

Other Information _____

_____