

**2009-2010 STRETCH THE IMAGINATION**

**CONTACT AND EMERGENCY MEDICAL RELEASE**

Child's Full Name: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zipcode \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_

Email: \_\_\_\_\_

Cellular: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Company Name \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_

Email: \_\_\_\_\_

Cellular#: \_\_\_\_\_

If parents live separately, note second parent's address and phone number.

Home Address \_\_\_\_\_

Home Phone #: \_\_\_\_\_

**PERSONS AUTHORIZED TO TAKE CHILD FROM CENTER**

Identification will be asked for at the time of pick-up. If you wish to include photographs of authorized persons, please do so.

Parent: \_\_\_\_\_ Parent \_\_\_\_\_

Those other than parents who are authorized to pick up your child:

Name: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_

Address: \_\_\_\_\_

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**CONTACT AND EMERGENCY MEDICAL RELEASE**

**MEDICAL AUTHORIZATION FORM**

CHILD'S FULL NAME:

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INSURANCE COVERAGE & NUMBER:

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DOCTOR NAME/ADDRESS/PHONE:

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LIST ALL ALLERGIES/HEALTH PROBLEMS/NEEDED MEDICATIONS:

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**AUTHORIZATION FOR MEDICAL TREATMENT**

As my child's legal guardian, I hereby give Stretch the Imagination and the employees thereof, permission to obtain medical treatment for my child\_\_\_\_\_.

I am responsible for the payment of such medical treatment. I authorize personal information needed for the treatment of my child to be released to medical/hospital personnel.

FOR MEDICAL AUTHORIZATION, SIGN HERE:

Parent/Legal Guardian :

\_\_\_\_\_ Date: \_\_\_\_\_

Print Name:

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