CDC Volunteer Information Card

Name:_____
Address:_____
E-mail Address:_____
Home Phone:_____ Cellular Phone:_____

Emergency Contacts:

Name:_____ Phone:_____
Name:_____ Phone:_____
Name:_____ Phone:_____

Consent for Medical Treatment

Solana Beach Child Development Center

I hereby give consent to the Solana Beach Child Development Center to provide all emergency dental, or medical care prescribed by a duly licensed Physician (M.D.), Osteopath (D.O.), or Dentist (D.D.S.) at our expense. This care may be given under whatever conditions are necessary to preserve my life, limb or wellbeing. In such event, it is understood that reasonable conscientious effort will be made to notify my family or emergency contacts promptly.

Parent Signature:_____ Date:_____

Medical Information

Physician:_____ Phone:_____
Medical Plan & Number:_____
Dentist:_____ Phone:_____
Medical Plan & Number:_____
If Physician cannot be reached, what action should be taken?
Call Emergency Hospital:_____ Other:_____
Allergies and/or other medical or critical information:_____
_____
_____
_____