Coppell Child Development Center
Annual Medical and Emergency Information

Child's Full Name: _____

Date of Birth: _____ Sex: _____ Height / Weight: _____

Father / Guardian: _____ Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Mother / Guardian: _____ Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Doctor: _____ Phone #: _____

Preferred Dentist: _____ Phone #: _____

Known Health Problems: _____

Known Allergies to food or medication: _____

I authorize CCDC to release my child to the individuals listed below in the event of an emergency.

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Drivers License # _____

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Drivers License # _____

Name: _____ Relationship: _____ Daytime Phone: _____

Address: _____

Name: _____ Relationship: _____ Daytime Phone: _____

In case of medical emergency, I (We) authorize the adults listed above to take my child to:

_____

Preferred hospital and address

My (our) Child is / is not (circle one) covered by hospitalization and / or surgical insurance.

The Insurance Company name is: _____ Policy / Member No. _____

I (We) authorize Coppell Child Development Center to obtain emergency medical treatment, at or away from our location and transport them to that location, if and when the school deems it necessary.

Parent / Guardian Signature: _____ Date: _____