



CHLA Child Development Center

Drop In Care Emergency Information Card & Medical Release Form

Please note: This service is only provided for children ages 1-10 years old.

Child's Name	Age	Does this child have sickle cell disease?
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No
3.		<input type="checkbox"/> Yes <input type="checkbox"/> No
4.		<input type="checkbox"/> Yes <input type="checkbox"/> No
5.		<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Parent/Guardian: _____

Cell/Phone # _____ Other phone # _____

Emergency Contacts:

(The child(ren) may be released to the following people/person (with proper identification):

- 1.) Name: _____ Relationship: _____
Home Phone # _____ Work Phone # _____
- 2.) Name: _____ Relationship: _____
Home Phone # _____ Work Phone # _____
- 3.) Name: _____ Relationship: _____
Home Phone # _____ Work Phone # _____

As the parent or authorized representative, I hereby give consent to Childrens Hospital of LA, Child Development Center to obtain all emergency medical or dental care prescribed by a duly licensed Physician (M.D.) Osteopath (D.O.) or Dentist (D.D.S.) for _____
Child(ren)'s name(s)

This care may be given under whatever conditions are necessary to preserve the life, limb or well being of the child named above.

CHILD HAS THE FOLLOWING MEDICATION/ OR FOOD ALLERGIES AND/OR SPECIAL NEEDS:

(Please specify name of the child) _____

Signed _____ Relationship _____ Date _____