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ACCIDENT AND EMERGENCY INFORMATION

Client Name _____ Birth Date _____

Home Address _____ Hm# _____

Legal Guardian/Father _____ Wk# _____ Cell# _____

Legal Guardian/Mother _____ Wk# _____ Cell# _____

Emergency Contact _____ Hm# _____ Cell# _____

Doctor _____ Dr's # _____ Nearest Hospital _____

List of medical conditions your child has, including allergies: _____

List of medications: _____

Does your child have seizures? Yes ___ No ___ Are they controlled by medication? Yes ___ No ___



**IN CASE OF A DISASTER, WHAT ARE YOUR INSTRUCTIONS OR WHERE
WOULD YOU LIKE YOUR CHILD TAKEN?**

Name _____
Address _____
Phone _____
Instructions: _____



PERMISSION FOR EMERGENCY TREATMENT

Legal Guardian/Parent Signature _____

Date _____

(I)(We), the undersigned, parent/legal guardian of _____ authorize Bay Respite Care at 3272 Sonoma Blvd, Suite 4, Vallejo, CA 94590 (707/644-4491) as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provision of the Medicine Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable; and neither said agent or any organization assumes any financial responsibility for exercising this action.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California and remains effective until revoked in writing and delivered to said agent(s).