

Emergency Information Record

"In the event that I cannot be reached, I hereby give my permission for my child to receive any necessary emergency medical care or treatment. I understand that every effort will be made to contact me or my spouse before such action is taken. I will be responsible for the payment for such treatment."

Child's Name: _____ Date of Birth: _____

Address: _____

Name of Mother: _____

Business Address: _____

Home Phone: _____

Work Phone: _____

Name of Father: _____

Business Address: _____

Home Phone: _____

Work Phone: _____

Person(s) to contact if parents are unavailable:

Name: _____ Relationship to child: _____

Address: _____

Phone: _____ Mobile: _____

Child's Physician: _____ Phone: _____

Hospital Preference: _____

Signature of Parent/Guardian

Date: _____

HAZ-ZEBBUG: 93, Triq Frans Sammut, Haz-Zebbug ZBG1906 ☎ 2165 1334

HAL-QORMI: 145, St. Bartholomeo Street, Hal-Qormi QRM 2182 ☎ 2752 4448

SIGGIEWI: 6, Triq Il-Hsad, Siggiewi SGW 2045 ☎ 2146 5558