

## Serendipity's Class Card

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Phone (work) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ (home) \_\_\_\_\_

\_\_\_\_\_ (cell) \_\_\_\_\_

Parent Name: \_\_\_\_\_ Phone (work) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ (home) \_\_\_\_\_

\_\_\_\_\_ (cell) \_\_\_\_\_

Names and numbers of others authorized to take child from the facility and to call in case of emergency:

\_\_\_\_\_  
\_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

As the parent or authorized representative, I hereby give consent to Serendipity Early Care and Education Center's staff 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's name). This care may be given under whatever conditions are necessary to preserve the life, limb or well being of the child named above.

Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_