

ST. LUKE SUMMER PROGRAM- EMERGENCY CONTACT/PICKUP FORM

Summer 2026

Please note: We will need one form for **each child.**

Group Name: _____ Weeks Attending: _____

Days Attending: _____ Hours Attending: _____

Child's Last Name: _____ First Name: _____

Address: _____ City: _____ Zip: _____

Child's Date of Birth: _____ Sex: _____ Allergies: _____

Mom's Name: _____

Dad's Name: _____

Mom's Cell #: _____

Dad's Cell #: _____

Mom's Work #: _____

Dad's Work #: _____

Mom's Email: _____

Dad's Email: _____

Occupation: _____

Occupation: _____

Child's Source of Medical Care/Primary Care Physician's Name: _____ Phone #: _____

Child's Dentist Name: _____ Phone #: _____

Name of Medical Facility/Hospital: _____ Phone #: _____

In case of an emergency, if I cannot be reached, I hereby give my permission to St. Luke to seek emergency medical treatment for my child. _____ Yes _____ No

In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on this form) necessary for the proper health and well-being of my child. _____ Yes _____ No

Please indicate who we can contact in case of an emergency and who is authorized to pick up your child when you are unable. (Please, do not list a parent, you are the first we will call).

	<u>Pick Up</u>	<u>Emergency</u>
Name: _____	Relationship To Child: _____	_____
Home Phone: _____	Cell Phone: _____	_____
Name: _____	Relationship To Child: _____	_____
Home Phone: _____	Cell Phone: _____	_____
Name: _____	Relationship To Child: _____	_____
Home Phone: _____	Cell Phone: _____	_____

Parent Signature: _____ Date: _____