

# ST. LUKE SUMMER PROGRAM- EMERGENCY CONTACT/PICKUP FORM

Summer 2024

**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: _____		