TRIAGE
Emergency Contact Information 2008

Confidential medical information will remain confidential and will not be released except as required by law.

Last Name of Family: ____

Address: ________________________________ City: ___________________ Zip: _________

Home Phone: _____________________________ Primary email address: ___________________

Child's name: ____

(First) (Initial) (Last)

In case of illness or emergency, call:

Parent/Guardian (1) Name: ____

Business phone: ____

Beeper/cell phone: ____

Parent/Guardian (2) name: ____

Business phone: ____

Beeper/cell phone: ____

Designated alternate(s) if parent/guardian is unavailable:

Name: ____

Phone: ____

Name: ____

Phone: ____

☐ **Yes** ☐ **No** **Permission to dispense medication**

Medications may be dispensed only with written permission from the parent/guardian or doctor.

☐ **Yes** ☐ **No** **Permission to contact physician/ambulance**

In case of emergency and I cannot be located, I hereby authorize TRIAGE to call our physician (listed below) and ambulance if necessary.

☐ **Yes** ☐ **No** **Permission for emergency treatment**

In case of emergency and I cannot be located, I hereby authorize TRIAGE to take my child to a hospital and receive emergency treatment by a physician.

Family physician: ____

Address: ____
Phone: ____

Family dentist: ____
Address: ____
Phone: ____

Insurance Company: ____
Policy Holder: ____
Contract#: ____

The hospital of your choice is: *(check one)*

- ☐ Spectrum/Blodgett
- ☐ Spectrum/Butterworth
- ☐ Metro Health
- ☐ St. Mary's
- ☐ Urgent Care Clinic: ____
- ☐ Other: ____

TRIAGE will attempt to use the hospital of your choice for care of your child, but may use a different hospital in its discretion.

Please identify any significant medical conditions (i.e. asthma, diabetes, etc.), major illnesses, or injuries that may affect your child's participation in TRIAGE activities.

____
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Does your child have any health problems or allergies/reactions to medications, foods, bee stings, etc.? Please list and briefly describe reaction, treatment, etc.

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____

Does your child take any medications at home? If so, please list them below.

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____ ____________________

Signature of Parent/Guardian for Emergency Authorization **Date**