



**Office Use Only:**

Case Number: \_\_\_\_\_

Opening Date: \_\_\_\_\_

Opened By (Initial): \_\_\_\_\_

**EMERGENCY CONTACT/INTAKE FORM**

(PLEASE PRINT LEGIBLY AND COMPLETE ALL INFORMATION)

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent/Legal Guardian #1: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Place of Work: \_\_\_\_\_ Work Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Parent/Legal Guardian #2: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Place of Work: \_\_\_\_\_ Work Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Emergency Contact Information (whom we may contact or release a child to if parent or guardian is unavailable)\*:**

Primary Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Permission to Pick-Up (whom we may release a child to if parent or guardian is unavailable, no confidential information will be shared with the individuals below):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**For the protection of your child, ID will be required at the time of pick-up.**

\* Fee Agreement Release Designees

**Child's Health Information (Mandatory):**

Name of Insurance Plan: \_\_\_\_\_

Medical ID Number: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Name/Number of Child's Doctor: \_\_\_\_\_

Name/Number of Child's Dentist: \_\_\_\_\_

Medical Assistance Number: \_\_\_\_\_

Special Concerns, Diagnosis: \_\_\_\_\_

\_\_\_\_\_

Allergies (including reaction): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dietary Restrictions: \_\_\_\_\_

\_\_\_\_\_

Does your child have an EPI-Pen?  Yes  No Other Medications?  Yes  No

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please contact school about medication administration form; we are unable to give medication without the completion of this form**

**Parent/Legal Guardian Consent and Agreement for Emergencies:**

As parent/legal guardian, I give consent to have my child receive first aid by facility staff, and, if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance.

I give permission to WVCA to post allergy information within the school for my child's safety)

I give consent for the emergency contact person listed above to *act on my behalf until I am available*. I agree to review and update this information whenever a change occurs.

Date: \_\_\_\_\_ Parent/Legal Guardian #1: \_\_\_\_\_

Date: \_\_\_\_\_ Parent/Legal Guardian #2: \_\_\_\_\_

**Office Use Only:**

Referring Agent: \_\_\_\_\_

Services: ( ) PT ( ) OT ( ) ST ( ) SI