SCOPE Emergency Information Authorization Card

Student's Name: ______________________ D.O.B. __________

Address: ______________________ Telephone: __________

Home School: __________ Teacher: __________ Program Site: __________

Physician: ______________________ Phone Number: __________

Father's Name: ______________________ Address: __________

Father's Business Address: ______________________ Work #: __________

Father's Cell Phone: ______________________ Other Phone: __________

Mother's Name: ______________________ Address: __________

Mother's Business Address: ______________________ Work #: __________

Mother's Cell Phone: ______________________ Other Phone: __________

Pick Up Restrictions: ______________________

Indicate Special Instructions: (allergies, medication, etc/) ______________________

(over)

Provide information of local adults who can be reached during program hours, if necessary, who are authorized to pick up my child (a neighbor is strongly suggested):

1. Name: ______________________ Relationship to child: __________

Address: ______________________

Home Phone: ______________________ Cell Phone: __________

2. Name: ______________________ Relationship to child: __________

Address: ______________________

Home Phone: ______________________ Cell Phone: __________

3. Name: ______________________ Relationship to child: __________

Address: ______________________

Home Phone: ______________________ Cell Phone: __________

In the event parents cannot be reached in a medical emergency, I give permission to SCOPE to seek medical attention from a physician and/or hospital.

Parent/Guardian Signature: ______________________

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