UNIVERSITY OF LOUISVILLE
EARLY LEARNING CAMPUS

FOR STAFF USE ONLY

School Year **2017-18**

Classroom _____

Medical Release Form

Child's Name: _____ **Birth Date:** _____

Child's Doctor: _____ Phone Number: _____

Preferred Dentist: _____ Phone Number: _____

Preferred Hospital: _____ Phone Number: _____

Insurance Information

Primary Insurance

Insurance Carrier: _____ Subscriber: _____

ID#: _____ Subscriber Date of Birth: _____

Group #: _____ Relationship to Subscriber: _____

Secondary Insurance

Insurance Carrier: _____ Subscriber: _____

ID#: _____ Subscriber Date of Birth: _____

Group #: _____ Relationship to Subscriber: _____

Please be sure that we have up-to-date emergency information at all times.

I hereby give permission for the Early Learning Campus to seek medical care, for my child/children, in the event of any medical emergency.

_____ _____

Signature of Parent or Guardian **Date**

UNIVERSITY OF LOUISVILLE
EARLY LEARNING CAMPUS

FOR STAFF USE ONLY	
School Year	**2017-18**
Classroom	_____

Emergency Care

Should the need arise the following emergency treatment procedure will be followed:

- A trained and certified staff member will take whatever immediate steps necessary to stabilize the child's condition.
- If further care is needed, appropriate medical personnel will be contacted (i.e. 911)
- Staff will notify Caregiver/Guardian of situation as soon as possible

I have read and understand the above outlined emergency care procedures.

_____ _____

Signature of Parent or Guardian **Date**