



Joyland
CHILD DEVELOPMENT CENTER
North

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home Phone _____ Work Phone _____

Mother's Name _____

Home Phone _____ Work Phone _____

Person to notify in an emergency and parents cannot be reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical facility the center uses Northeast Georgia Medical Center

Address: 743 Spring St. NE Gainesville Georgia 30501

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if Joyland North cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Signature (Parent/Guardian) _____

Witness by _____ Date _____