Zōcalo OUTREACH
1380 Ammons Street
Lakewood, CO 80214
(303) 237-9519
http://ZocaloOutreach.org

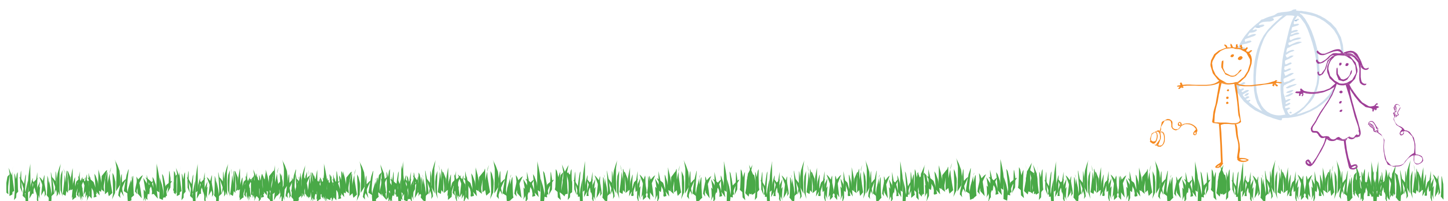
Emergency Information

Child's Name:	Age:	Date of Birth:
Address, City, State, Zip:		
Parent's Name:	Home Phone:	Cell Phone:
Address, City, State, Zip:		
Employer:	Work Phone:	
Employer's Address, City, State, Zip:		
Parent's Name:	Home Phone:	Cell Phone:
Address, City, State, Zip:		
Employer:	Work Phone:	
Employer's Address, City, State, Zip:		

Additional Persons Authorized to Pick-up Child

Name:	Home Phone:	Cell Phone:
Address, City, State, Zip:		
Name:	Home Phone:	Cell Phone:
Address, City, State, Zip:		

Emergency Information Continued on Next Page



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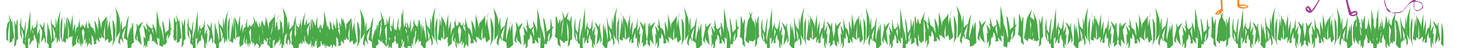
Emergency Information (continued)

Relative or Friend We May Contact in Case of Emergency Should Parents/Guardian Be Unavailable:

Name:	Home Phone:	Cell Phone:
Address, City, State, Zip:		
Name:	Home Phone:	Cell Phone:
Address, City, State, Zip:		



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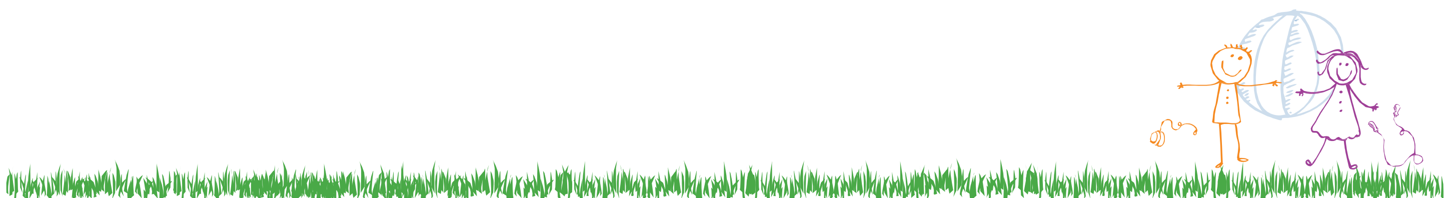
Medical Information

PLEASE ATTACH PHOTOCOPY OF CURRENT IMMUNIZATION CARD TO THIS FORM.

Is your child taking any medications? Yes or No **If yes, please indicate:**	
Is your child restricted from normal physical activity in any way? Yes or No **If yes, please indicate:**	
Known allergies/Dietary needs:	
Any other special attentions/behaviors? (i.e. seizures, ADD, ADHD, Asthma, etc.)	
Behavior concerns? Yes or No **If so, what techniques are used to help your child cope?**	
Doctor's Name:	**Phone:**
Address, City, State, Zip:	
Dentist's Name:	**Phone:**
Address, City, State, Zip:	
Preferred Hospital:	**Phone:**
Address, City, State, Zip:	

Medical Information Continued on Next Page



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Medical Information (continued)

PLEASE NOTE:

1) A child who appears ill upon arrival will not be admitted to the program.
2) Medical authorizations and physician information are essential to properly care for your child during an emergency.
3) It is the responsibility of the parents(s) to provide truthful and accurate information on this emergency form. Further, it is the responsibility of the parent(s) to update this information as needed.

I authorize the ZÓCALO OUTREACH PROGRAM to take my child to the above named physician or facility for medical treatment in the event of an emergency, in which neither parent or guardian can be reached. I authorize the employees and agents to act for me (and/or my child) according to their best judgment and ability in case of emergency. I authorize any licensed physician or medical treatment center to treat my child in case of an emergency in which the above named physician cannot respond.

Signature of Parent/Legal Guardian Date