KINGDOM KREW
A ministry of Oasis Church

ID Emergency Information

1730 Curtner Ave
San Jose, CA 95125
408.883.8224
KingdomKrew.org
Lic# 434403618
Lic#

Childs Name: _____ DOB: _____ M ☐ F ☐
Last, First, MI

School: _____ Grade: _____ Rm #: _____ KK Start Date: _____

Child Lives with: _____

***Mother/Guardian*:** _____ CDL#: _____

Address: _____
Street City State Zip

Phone **Cell:** _____ Work: _____ Other: _____

Email: _____

Occupation: _____ Employer: _____

Father/Guardian: _____ CDL#: _____

Address: _____
Street City State Zip

Phone **Cell:** _____ Work: _____ Other: _____

Email: _____

Occupation: _____ Employer: _____

PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(People listed will be authorized to pick-up my child without further notice and must be 16 years or older.)

Name: _____ Relationship: _____ Ph #: _____ CDL#: _____

Name: _____ Relationship: _____ Ph #: _____ CDL#: _____

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Name: _____ Relationship: _____ Ph #: _____ CDL#: _____

Name: _____ Relationship: _____ Ph #: _____ CDL#: _____

Name: _____ Relationship: _____ Ph #: _____ CDL#: _____

Name: _____ Relationship: _____ Ph #: _____ CDL#: _____

Name: _____ Relationship: _____ Ph #: _____ CDL#: _____

Name: _____ Relationship: _____ Ph #: _____ CDL#: _____

Date: _____

CONSENT FOR MEDICAL TREATMENT

AS THE PARENT, AGENCY REPRESENTATIVE OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO *KINGDOM KREW / OASIS CHURCH* TO PROVIDE ALL EMERGENCY DENTAL OR MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.), OSTEOPATH (D.O.), OR DENTIST FOR _____. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE LIFE, LIMB OR WELL BEING OF MY DEPENDANT.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

In case of Medical Emergency when parent or guardian cannot be reached contact: (List in order to be contacted.)

1. **Name**:_____ Relationship:_____ Ph #:_____
2. **Name**:_____ Relationship:_____ Ph #:_____
3. **Name**:_____ Relationship:_____ Ph #:_____

INSURANCE/MEDICAL RESPONSE INFORMATION

Insurance carrier:_____ Policy No.:_____

Physician to be called in case of emergency:_____

Address:_____ Phone:_____

Dentist to be called in case of an emergency:_____

Address:_____ Phone:_____

Preferred Family Hospital to be called in case of an emergency:_____

Address:_____ Phone:_____

*Please **list any food allergies or special problems, fears, conditions** that staff and medical personnel should be aware of.*

_____

_____

_____

_____

Signature of Parent or Guardian **Date**