ORIGINAL DOCUMENT

GREATER BERGEN COMMUNITY ACTION, INC.

241 Moore Street
Hackensack, NJ 07601
201-968-0200
www.bergencap.org

MEDICAL EMERGENCY PERMISSION FORM

Date_____

I give my permission for my child, _____ to receive emergency
Last Name First Name
medical treatment while he/she attends the Greater Bergen Community Action Program. A staff member trained in First Aid may give treatment or my child may be transported to a hospital if necessary. In an emergency evacuation or lockdown of the center, I allow the staff to comply with the protocols that were explained to me at intake. I give consent for my child's health care provider/ school nurse to discuss any medical information concerning my child.

Witness: _____ Name: _____
Staff Signature Address: _____
_____

****Signature** _____

Emergency Contact: _____

Relationship _____ Relationship_____
Phone: H _____ Phone: H _____
W _____ W _____
C _____ C _____

*** **MUST BE SIGNED BY PARENT OR LEGAL GUARDIAN ONLY***

CHILD'S MEDICAL DATA **DOB:** _____

1. Allergies: _____
2. Medications: _____
3. Latest DTaP: _____
4. Medical Conditions: _____Diabetes _____Heart/Blood Vessel Disease
_____Asthma _____ Sickle Cell Disease
_____Seizure Disorder _____Other

Doctor's Name:_____ Dentist's Name: _____
Address: _____ Address:_____
Phone: _____ Phone: _____