

PATH Annual Training - Child Information Sheet

Child(ren) Name(s)	Allergies	Age(s)	Additional Information
Parents/Foster Parents Names:	Home Phone		Cell Phone
Address	Email Address		
Person or Persons authorized to pick up Child (Name, Address, Phone #, and Relationship to Child)			
Person or Persons to contact in emergency should both parents be unavailable (Name, Phone #, and Relationship to Child)			

Statement of Consent

In the event of an emergency or non-emergency situation requiring medical treatment, I (We), _____, hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel. Door of Hope Inc. is not responsible for any accidents and/or injuries.

Signature: _____

Date: _____