EVACUATION INFORMATION
(Must have one for every child in center)

Child's Name:________________________________ Date of Birth:______________________________

Address:____

Father's Name:______________________ HM. PH____________________WK. PH_________________

Mother's Name:_____________________ HM. PH____________________WK. PH_________________

In an emergency and the Parents cannot be reached:

Name:_____________________________ HM. PH____________________WK. PH_________________
Relationship:________________________

Name:_____________________________ HM. PH____________________WK. PH_________________
Relationship:________________________

Child's
Doctor:___________________________________Phone:___________________________________

Medical Facility the Center Uses: **Conroe Regional Medical Center** Phone: **936-539-1111**
Address**: 501 Medical Center Blvd. Conroe, TX 77304**

Child's Allergies:____

Current Prescribed Medication's:____

Child's Special Medical Needs and Conditions:____

In the event of an emergency involving my child, and if ABC ACADEMY 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 and to hold harmless and release ABC ACADEMY from all liability.

Parent Signature:_______________________________ Date:_________________________________