**Family Basics**

Fill out one form for each family member.

|  |  |
| --- | --- |
| Full Name |  |

**Home Information**

|  |  |
| --- | --- |
| Address |  |
| City, State, Zip |  |
| Phone |  |
| Cell |  |
| Email |  |

**Work/School Information**

|  |  |
| --- | --- |
| Company |  |
| Title |  |
| Address |  |
| City, State, Zip |  |
| Phone |  |
| Cell |  |
| Email |  |

**Other Personal Information**

|  |  |
| --- | --- |
| Date of Birth |  |

**Additional Work Information**

|  |  |
| --- | --- |
| Department |  |
| Assistant Name |  |
| Assistant Phone |  |
| Boss’s Name |  |
| Boss’s Phone |  |
| HR Contact |  |
| HR Phone |  |
| 401K/Pension Contact |  |
| 401K/Pension Phone |  |

**Child Care Information**

Fill out one form for each child.

**Parents**

|  |  |
| --- | --- |
| Name |  |
| Work Phone |  |
| Cell |  |
| Email |  |

|  |  |
| --- | --- |
| Name |  |
| Work Phone |  |
| Cell |  |
| Email |  |

|  |  |
| --- | --- |
| Name |  |
| Work Phone |  |
| Cell |  |
| Email |  |

|  |  |
| --- | --- |
| Name |  |
| Work Phone |  |
| Cell |  |
| Email |  |

**Neighbors**

|  |  |
| --- | --- |
| Name |  |
| Work Phone |  |
| Cell |  |
| Email |  |

|  |  |
| --- | --- |
| Name |  |
| Work Phone |  |
| Cell |  |
| Email |  |

**Pediatrician**

|  |  |
| --- | --- |
| Name |  |
| Phone |  |

**Special Needs and Instructions**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

**Allergies**

|  |  |
| --- | --- |
| Child Name |  |
| Type |  |
| Notes |  |
| Child Name |  |
| Type |  |
| Notes |  |
| Child Name |  |
| Type |  |
| Notes |  |

**Pharmacy**

|  |  |
| --- | --- |
| Name |  |
| Phone |  |

|  |  |
| --- | --- |
| Name |  |
| Phone |  |

**Medications/Supplements**

|  |  |
| --- | --- |
| Child Name |  |
| Medication |  |
| Dosage |  |

|  |  |
| --- | --- |
| Child Name |  |
| Medication |  |
| Dosage |  |

|  |  |
| --- | --- |
| Child Name |  |
| Medication |  |
| Dosage |  |

|  |  |
| --- | --- |
| Child Name |  |
| Medication |  |
| Dosage |  |

|  |  |
| --- | --- |
| Child Name |  |
| Medication |  |
| Dosage |  |

**Insurance**

|  |  |
| --- | --- |
| Primary Name |  |
| Address |  |
| Policy Number |  |
| Phone |  |

|  |  |
| --- | --- |
| Secondary Name |  |
| Address |  |
| Policy Number |  |
| Phone |  |

**Emergency Authorization Form**

Date­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_

In my absence, I authorize emergency medical treatment for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. My child is being cared for by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Sincerely,

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_

In my absence, I authorize emergency medical treatment for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. My child is being cared for by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Sincerely,

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_

In my absence, I authorize emergency medical treatment for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. My child is being cared for by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Sincerely,

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Elder Care Information**

**Basics**

|  |  |
| --- | --- |
| Name/DOB |  |
| Address |  |
| Phone |  |
| Cell |  |
| Medical Conditions |  |

**Medical Basics**

|  |  |
| --- | --- |
| Blood Type |  |
| Primary Physician Name |  |
| Phone |  |
| Specialist Physician Name |  |
| Phone |  |
| Specialist Physician Name |  |
| Phone |  |
| Specialist Physician Name |  |
| Phone |  |

**Allergies**

|  |  |
| --- | --- |
| Food Allergies |  |

|  |  |
| --- | --- |
| Medicine Allergies |  |

|  |  |
| --- | --- |
| Other Allergies |  |

**Pharmacy**

|  |  |
| --- | --- |
| Name |  |
| Phone |  |

**Medications/Supplements**

|  |  |
| --- | --- |
| Name |  |
| Number |  |
| Name |  |
| Number |  |
| Name |  |
| Number |  |
| Name |  |
| Number |  |

**Surgeries**

|  |  |
| --- | --- |
| Type |  |
| Physician |  |
| Date |  |
| Diagnosis |  |
| Surgery Location |  |
| Test Result |  |

|  |  |
| --- | --- |
| Type |  |
| Physician |  |
| Date |  |
| Diagnosis |  |
| Surgery Location |  |
| Test Result |  |

|  |  |
| --- | --- |
| Type |  |
| Physician |  |
| Date |  |
| Diagnosis |  |
| Surgery Location |  |
| Test Result |  |

**Insurance**

|  |  |
| --- | --- |
| Primary Name |  |
| Address |  |
| Policy Number |  |
| Phone |  |

|  |  |
| --- | --- |
| Secondary Name |  |
| Address |  |
| Policy Number |  |
| Phone |  |

**Key Contacts**

|  |  |
| --- | --- |
| Emergency Contact Name(s) |  |
| Phone |  |

|  |  |
| --- | --- |
| Emergency Contact Name(s) |  |
| Phone |  |

|  |  |
| --- | --- |
| Emergency Contact Name(s) |  |
| Phone |  |

|  |  |
| --- | --- |
| Emergency Contact Name(s) |  |
| Phone |  |

**Other Information**

|  |  |
| --- | --- |
| Organ Donor Y/N |  |
| Living Will Location |  |
| Power of Attorney Location |  |