



722 East Ridgewood Avenue  
Ridgewood, NJ 07450  
201-445-2552  
EMAIL - [info@fpnsr.com](mailto:info@fpnsr.com)  
[www.fpnsr.com](http://www.fpnsr.com)

**2018 - 2019**  
**Medical Emergency Form**  
***(Please Print Clearly)***

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(First) (M.I.) (Last)

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Pre-existing medical conditions: \_\_\_\_\_

Home Tel. # (\_\_\_\_) \_\_\_\_\_

Mom Cell # (\_\_\_\_) \_\_\_\_\_ Dad Cell # (\_\_\_\_) \_\_\_\_\_

Parents' Names: Mom \_\_\_\_\_ Dad \_\_\_\_\_

Physician's Name \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

People to call if a parent cannot be reached:

1. \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_\_

2. \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_\_

In the event I cannot be reached, I hereby authorize the First Pres. Nursery School Director or Teacher in Charge to have my child transported to a hospital for emergency treatment. I give my permission to the hospital and/or my child's Pediatrician to provide emergency medical treatment for my son/daughter. Medical personnel are granted consent to carry out required emergency treatment for my son/daughter. I understand that I am responsible for all medical costs incurred with regard to examinations and medical services rendered.

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date