



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: _____