



Emergency Contact Child Release Authorization

Child's name:	Date of Birth:
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Address:

Allergies/Special Needs:

Parent/Guardian:	Home phone:	Cell phone:
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Employer:	Work phone:	Pager:
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Email Address:

Parent/Guardian:	Home phone:	Cell phone:
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Employer:	Work phone:	Pager:
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Email Address:

Please list a minimum of three (3) additional people authorized to contact in case of emergency:

1)	Home phone:	Cell/Work phone:
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Address:	Relationship:
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2)	Home phone:	Cell/Work phone:
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Address:	Relationship:
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3)	Home phone:	Cell/Work phone:
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Address:	Relationship:
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EMERGENCY TREATMENT AUTHORIZATION

I give SPECTRUM STATION permission to make whatever emergency measures (i.e.: first aid; disaster evacuation; emergency services) are judged necessary for the care and protection of my child while under the supervision of SPECTRUM STATION.

In cases of medical emergency, I understand that my child will be transported to the nearest hospital (NORTH KANSAS CITY HOSPITAL) by the local emergency unit for treatment, if the local emergency resource deems it necessary. It should be understood that in some medical situations, the staff will need to contact the local emergency resource before contacting the parent, guardian, and/or child's physician.

EMERGENCY MEDICAL INFORMATION:	DOCTOR:	Phone:
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ALLERGIES/SPECIAL MEDICAL NEEDS:

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PARENT/GUARDIAN SIGNATURE:	DATE:
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