		101		TFΔM
 	100	' I ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		
 п.	1R R	11.4	146	

1 n	VER'	V TC	A B A
		*	Δ IVI

SARASOTA MEMORIAL HEALTH CARE SYSTEM CHILD CARE SERVICES EMERGENCY OR HURRICANE REGISTRATION FORM (FORM D) CHILDREN 6 WEEKS-17 YRS.

	Parent's Signature	
Employee/F	Parent's Printed Name	Date
I have read and fully un	derstand the above information	:
I understand that some	children may be relocated to ar	approved shelter should space become an issue.
I understand that when	I am not working, I am respons	ible for my child.
I understand that my ch	ild may not be admitted for care	e unless I provide the attached list of necessities.
I clearly understand and administer medications		on daily medication, I am responsible to maintain and
I understand that I am r	esponsible for all medical care	for my child.
I give my permission situation.	o consult a physician or heal	th source if I cannot be reached in an emergency
		Phone:
		Phone:
Person(s) to call if pare	nts cannot be reached and who	may take child from Child Care:
	EMERGENCY IN	NFORMATION
	Pager Needs (allergies, health, med	
	-	
	Pagar	Department Cell Phone
		Age
Child's Name:		Age
Child's Name:		Age

Revised 6/07