

**Wyckoff Reformed Church Nursery School**  
**580 Wyckoff Avenue, Wyckoff, NJ 07481**  
**Tel # (201) 847-1330 Fax # (201) 891-1260**

**Medical Emergency Card**  
(Please Print)

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(First) (Middle Initial) (Last)

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

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

Mother's Work Tel. # (\_\_\_\_) \_\_\_\_\_ (Ext.) \_\_\_\_\_

Father's Work Tel. # (\_\_\_\_) \_\_\_\_\_ (Ext.) \_\_\_\_\_

See Other Side

Child's Known Allergies \_\_\_\_\_

Child's Physician \_\_\_\_\_ Tel. # (\_\_\_\_) \_\_\_\_\_

Office Address \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Policy Number \_\_\_\_\_

List others who would have knowledge of where you could be reached:

Name \_\_\_\_\_ Tel. # (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Tel. # (\_\_\_\_) \_\_\_\_\_

In the event I cannot be reached, I hereby authorize the WRCNS Director or Teacher in Charge to take my child to a hospital for emergency treatment. 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