

**KAILUA METHODIST PRESCHOOL
EMERGENCY INFORMATION AND RELEASE**

In the event of a medical emergency I give Kailua Methodist Preschool permission to contact:

Dr. _____ at _____
(name) (address and phone number)

Parent/Guardian signature

Date

In the event of a medical emergency I give Kailua Methodist Preschool permission to transport my child, _____, by private car or ambulance to Castle Medical Center for emergency treatment and will not hold KMP, it's employees or KUMC, liable for any accidents that may occur during transport knowing they will do their best on behalf of my child's safety.

Parent/Guardian signature

Date

Please list below any information Kailua Methodist Preschool needs to know about your child that we should alert medical personnel of in the event of an emergency.

Please include allergies to medicines, foods, or other substances; past surgeries or other information necessary for medical personnel to determine the best care and treatment for your child.

If none, please mark "None Known."

____ Continued on separate page.