

**One Night Out (O.N.O) at the Boston Ability Center
Emergency Contact and Medical Information for a Child**

_____ Child's Name		_____ Date of Birth		M F Sex
_____ Parent's/Guardian's Name		_____ Parent's/Guardian's Name		
_____ Home Phone	_____ Work Phone	_____ Home Phone	_____ Work Phone	
_____ Address		_____ Address		
_____ City, ST ZIP Code		_____ City, ST ZIP Code		

Alternative Emergency Contacts

_____ Primary Emergency Contact		_____ Secondary Emergency Contact	
_____ Home Phone	_____ Work Phone	_____ Home Phone	_____ Work Phone
_____ Address		_____ Address	
_____ City, ST ZIP Code		_____ City, ST ZIP Code	

Medical Information

Hospital/Clinic Preference

_____ Physician's Name	_____ Phone Number
_____ Insurance Company	_____ Policy Number

Allergies/Special Health Considerations

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

_____ Parent's/Guardian's Signature	_____ Date
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I give permission for my child to participate in O.N.O evening activities. I release the Boston Ability Center and individuals from liability in case of accident during activities related to One Night Out, as long as normal safety procedures have been taken.

_____ Parent's/Guardian's Signature	_____ Date
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_____ Witness Signature	_____ Date
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