

**U.S. Geological Survey  
EMERGENCY CARE FOR MINORS FORM**

**IMPORTANT: ORIGINAL FORM MUST ACCOMPANY CHILD**

In case of an emergency, a USGS representative(s) will contact the worksite Federal Occupational Health facility or other local emergency response number. Every attempt will be made to contact a parent/guardian or designated emergency contact.

**Child's Name:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Child Resides With: Father ( ) Mother ( ) Both ( ) Guardian ( )

**Father's Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Guardian's Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Physician Information:**

My child's medical care is provided by: \_\_\_\_\_  
(name of doctor, clinic, or HMO) (phone)

**Medical Information** (Check any current health condition):

Allergies (be specific)

foods \_\_\_\_\_

medicines \_\_\_\_\_

bee sting or insect bite \_\_\_\_\_

Physical disability (be specific) \_\_\_\_\_

Respiratory (be specific) \_\_\_\_\_

Diabetes

Glasses  Contacts

Hearing problems  Hearing Aid(s)

Other Health Conditions : \_\_\_\_\_

List all medications and dosages the child receives on a continual basis: \_\_\_\_\_

\_\_\_\_\_  
The U.S. Geological Survey has my permission, in an emergency when I (or my physician) cannot be contacted, to take my child to (1) a Federal Occupational Health facility, when immediately accessible; or (2) the emergency room of the nearest hospital; and the Federal Occupational Health facility and/or hospital and their medical staffs have my authorization to provide treatment which a physician deems necessary for the well-being of my child.

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE DATE**