**St. Peter's ECDC Admission & Emergency Form** **2026-2027**
**St. Peter's ECDC Director: Director Amanda Fasullo**

**Form must be filled out by a Parent/Legal Guardian**

**Child's Full Name** _____ Child goes by: _____

Gender: M / F DOB: _____/_____/_____ Age as of Sept. 1st: _____

Child's Home Address _____ City _____ Zip _____

Child lives with: Both parents _____ Mom ____ Dad ____ Guardian ____

**Mother's Name** _____

Address if different from child's _____ City _____ Zip code _____

Primary Phone (_____) _____ E-mail _____

**Father's Name** _____

Address if different from child's _____ City _____ Zip code _____

Primary Phone (_____) _____ E-mail _____

Office use only:
Admission: _____ Days: _____ Withdrawal: _____

**All are Required Fields – *All blanks must be filled.***

**Parent's Medical Insurance Carrier** _____ **Group Number** _____

**Name of Insured** _____ **Insurance Co. Phone Number** _____

**If parents cannot be reached, please contact:**

**Name** _____ **Relationship** _____

**Address** _____ **Phone ( _____ )** _____

**Physician's Name** _____ **Phone ( _____ )** _____

**Physician's Address** _____

**Hospital Preference** _____

**Hospital Address** _____ **Hospital Phone ( _____ )** _____

**Diagnosed Allergies** _____ **(if *none, please write NONE*)**

**EpiPen / AUVI-Q Needed: Yes____ No____** **Has your child had an anaphylactic shock Yes____ No____**

**Special Concerns or Needs:** (This includes, but is not limited to, an existing illness, previous serious illness & injuries, hospitalizations during the past 12 months, and any medications prescribed for long term use.)

**(If none, please write NONE)** _____

**AUTHORIZATION OF CONSENT TO TREAT A MINOR**: I hereby authorize St. Peter's ECDC to give my child Benadryl and to take my child to any licensed physician or hospital in a medical emergency.

_____ _____
**SIGNATURE OF PARENT OR LEGAL GUARDIAN** **DATE**