

Travel/Babysitter Binder
THIRTYHANDMADEAYS.COM
FOR PERSONAL USE ONLY

Cover

Travel Info

Emergency Contacts

Medical Info

Family Schedule

Meal Time

Food Info

House Rules

Medical Release

WHILE WE'RE AWAY

All the important info you need
for the

TRAVEL INFO

WHERE WE'LL BE

FLIGHT INFO

HOTEL INFO

BEST WAY TO GET
AHOLD OF US

WHEN WE'LL BE BACK

ADDITIONAL INFO

EMERGENCY CONTACTS

	Phone Number/Address
FRIENDS	
SCHOOL INFO	
CHURCH INFO	
DOCTORS	
DENTIST	
VETERINARIAN	

MEDICAL INFO

NAME & INFO	Phone Number/Address
PEDIATRICIAN	
ON CALL EMERGENCY	
INSURANCE	
MEDICATIONS	
FOOD ALLERGIES	
FIRST AID	

FAMILY SCHEDULE

TIME	SUN	MON	TUES	WEDS	THURS	FRI	SAT
MORNING							
AFTERNOON							
EVENING							

MEAL TIME

MEAL	TIME	IDEAS
BREAKFAST		
SNACKS		
LUNCH		
SNACKS		
DINNER		

FOOD INFO

BREAKFAST

Time:

LUNCH

Time:

DINNER

Time:

SNACKS

Time:

BEFORE BED:

FOOD ALLERGIES

Additional info:

HOUSE RULES

Basic Rules:

Rules for Technology:

Food not allowed to have:

Rooms that are off limits:

Rules for friends

Allowed to go to a friend's house?

Allowed to have friends over?

Bedtime Routine:

Additional Info:

MEDICAL RELEASE

Parent/Guardian Name: _____

Address: _____

Important Phone #'s: _____

Kids Names & Important Info:

FULL NAME BIRTHDATE ILLNESS, ALLERGIES, MEDICINES, ETC

In case of an emergency contact:

Name: _____

Relationship: _____

Phone #: _____

DOCTOR INFO

Primary: _____

Address: _____

Phone #: _____

DENTIST INFO

Dentist: _____

Address: _____

Phone #: _____

INSURANCE INFO

Company Name: _____

Policy Number: _____

Phone #: _____

MEDICAL RELEASE

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____ Relationship to you: _____

Reason for which release is intended: _____

Address of Minor: _____

Phone: _____ Emergency Phone: _____

Family Physician: _____ Phone: _____

Physician Address: _____ City: _____

List allergies, medications, contract, etc:

Health Insurance Information:

Company: _____ Policy: _____

Group: _____ Contract: _____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Date: _____ Signed: _____

To be completed by Notary:

State of: _____ Subscribed and sworn to before me

County of _____ This _____ day of _____

Notary Public