EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.
NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name Telephone (H) (W)
Last, First

Address
Street/Apt.#, City, State, Zip Code

2. Name Telephone (H) (W)
Last, First

Address
Street/Apt.#, City, State, Zip Code

3. Name Telephone (H) (W)
Last, First

Address
Street/Apt.#, City, State, Zip Code

Child's Physician or Source of Health Care Telephone

Address
Street/Apt.#, City, State, Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____Date

Child's Name Birth Date
Last, First

Enrollment Date Hours & Days of Expected Attendance

Child's Home Address
Street/Apt. #, City, State, Zip Code

Mother's Name Home Telephone
Last, First

Mother's Employer/School
Name, Address

Mother's Home Address (*If different from above)*
Street/Apt.#, City, State, Zip Code

Work Telephone Cellular Phone Beeper

Father's Name Home Telephone
Last, First

Father's Employer/School
Name, Address

Father's Home Address *(If different from above)*
Street/Apt.#, City, State, Zip Code

Work Telephone Cellular Phone Beeper

Name of Person Authorized to Pick Up Child *(daily)*
Last, First, Relationship to Child

Address
Street/Apt.#, City, State, Zip Code

ANNUAL UPDATES _____ _____ _____ _____
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

INSTRUCTIONS TO PARENT:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: Date of Birth:

Medical Condition(s):

Medications currently being taken by your child:

Date of your child's last tetanus shot:

Allergies/Reactions:

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for:

(2) If signs/symptoms appear, do this:

(3) To prevent incidents:

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED:

COMMENTS:

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

_____ _____
Name of Health Practitioner Date

_____ (_____)_____
Signature of Health Practitioner Telephone Number