

EMERGENCY CONTACT FORM

CHILD'S NAME		BIRTHDATE
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHOE NUMBER
BUSINESS ADDRESS		CELL PHONE NUMBER
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
BUSINESS ADDRESS		CELL PHONE NUMBER
EMERGENCY CONTACT PERSON(S) NAME		TELEPHONE NUMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELAEASED NAME ADDRESS		TELEPHONE NUMBER WHEN CHILD IS IN CARE
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER
ADDRESS		
SPECIAL DISABILITIES (IF ANY)		ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL OR DIETARY INFORMATON NECESSARY IN AN EMERGENCY SITUATION		MEDICAL SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT		
OBTAINING EMERGENCY MEDICAL CARE SIGNATURE _____ DATE _____		ADMIN. OF MINOR FIRST AID PROCEDURES SIGNATURE _____ DATE _____
WALKS AND TRIPS SIGNATURE _____ DATE _____		TRANSPORTATION BY THE FACILITY SIGNATURE _____ DATE _____
PERIODIC REVIEW REQUIRED EVERY 6 MONTHS		
SIGNATURE BELOW CONFIRMS ALL ABOVE INFORMATION IS CURRENT AND CORRECT		
1 ST PERIODIC REVIEW SIGNATURE OF PARENT/GUARDIAN _____ DATE _____		
2 ND PERIODIC REVIEW SIGNATURE OF PARENT/GUARDIAN _____ DATE _____		
3 RD PERIODIC REVIEW SIGNATURE OF PARENT/GUARDIAN _____ DATE _____		