

## 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 \_\_\_\_\_ Address \_\_\_\_\_  
Name

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 \_\_\_\_\_ Address \_\_\_\_\_  
Name

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 Telephone

**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: \_\_\_\_\_

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**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