



The Center for the Development of Children

4 Springdale Ave.
Dover, MA 02030

Sandy Blinn, Director

(508)785-1835

Emergency Information

(Please Print)

Child's Name: _____ Home Tel: () _____ - _____

Address: _____ DOB: _____

Where can parents be reached?

1. Parent/guardian name and address:

Cell/ Business No.:() _____ - _____

2. Parent/guardian name and address:

Cell/Business No.:() _____ - _____

List two neighbors or local relatives who will assume temporary care of your child if you cannot be reached:

1. Name: _____ Phone: () _____ - _____

Address: _____

2. Name: _____ Phone: () _____ - _____

Address: _____

In the unlikely event of accident or serious illness, I request that the Center for the Development of Children contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible for the school to contact this physician, the school may make whatever arrangements seem necessary.

Signature of Parent/Guardian: _____ **Date:** _____

Allergies:

Other conditions:

Local physician's name:

Local dentist name:

Town: _____

Town: _____

Phone () _____ - _____

Phone () _____ - _____