**\*Emergency Contact Form\***

Child’s Name: Click here to enter text. Date of Birth: Click here to enter text.

This form allows parents to authorize the release of their child, provides emergency contact information, and allows for the provision of emergency treatment for the above named child in the event that he/she becomes ill or injured while under program authority and the parent/guardian cannot be reached. **All** of the information must be completed or your child will not be able to attend the center.

**Parent/Guardian/Custodians with Whom the Child Resides.**

|  |  |
| --- | --- |
| Name: Click here to enter text. | Relationship to Child: Click here to enter text. |
| Address: Click here to enter text. |  |
| Home phone #: Click here to enter text. | Cell phone: Click here to enter text. |
| Employer: Click here to enter text. | Work phone: Click here to enter text. |
| Parent email: Click here to enter text. |  |
| Name: Click here to enter text. | Relationship to Child: Click here to enter text. |
| Address: Click here to enter text. |  |
| Home phone #: Click here to enter text. | Cell phone: Click here to enter text. |
| Employer: Click here to enter text. | Work phone#: Click here to enter text. |
| Parent email: Click here to enter text. |  |

**Persons to contact in case of an emergency: (must be local-w/in 30 min.-and someone other than you)**

|  |  |
| --- | --- |
| 1. Name: Click here to enter text. | Relationship to child: Click here to enter text. |
| Address: Click here to enter text. |  |
| Home phone: Click here to enter text. | Cell phone: Click here to enter text. |
| Employer: Click here to enter text. | Work phone: Click here to enter text. |
|  |  |
| 2. Name: Click here to enter text. | Relationship to child: Click here to enter text. |
| Address: Click here to enter text. |  |
| Home phone: Click here to enter text. | Cell phone: Click here to enter text. |
| Employer: Click here to enter text. | Work phone: Click here to enter text. |
|  |  |
| Are the above named people authorized to pick up your child: | [ ] Yes or [ ]  No (check one) |

**Is there any custody or restraining orders for persons who may attempt to pick up or have contact with the child?** (check one) [ ]  Yes or [ ] No

 If the answer to the above question is yes, please provide names/relationships and copy of any court orders.

|  |  |
| --- | --- |
| Name: | Relationship to Child: |

**Medical and Dental Information (Required for all ages)**

|  |  |
| --- | --- |
| **Physician Name:** Click here to enter text. | **Dentist Name:** Click here to enter text. |
| Address: Click here to enter text. | Address: Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Phone: Click here to enter text. | Phone: Click here to enter text. |
| Known Allergies: Click here to enter text. | Current Medications: Click here to enter text. |
| Insurance Company: Click here to enter text. |  |
| Policy #: Click here to enter text. |  |
| Hospital preference: Click here to enter text. |  |

**Is there anything else I should know about your child that may help us in an emergency?** (Special needs, speaks or understands a different language, allergies)

|  |
| --- |
| Add here: Click here to enter text. |
| Click here to enter text. |

Parent Electronic Signature: Click here to enter text. Date: Click here to enter text.