EMERGENCY FORM

Child's Name _____ Birth Date _____
         Last   First

Enrollment Date _____   Hours & Days of Expected Attendance _____

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

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: _____ W:	C:	H:
		Place of Employment: _____ W:	C:	H:

Name of Person Authorized to Pick up Child *(daily)* _____
                                     Last   First   Relationship to Child
Address _____
         Street/Apt. #   City   State   Zip Code

Any Changes/Additional Information_____

_____

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

— —

When parents/guardians 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 _____

INSTRUCTIONS TO PARENT/GUARDIAN:
  (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