EMERGENCY INFORMATION

_____
TODAYS DATE M/D/Y

_____ _____
CHILD'S FULL NAME BIRTH DATE M/D/Y

_____
HOME ADDRESS

Name(s) of Parent(s)/Guardian(s): Order to Contact 1, 2, 3 or B(Both)

_____ ☐
NAME CELL NUMBER HOME/WORK

_____ ☐
NAME CELL NUMBER HOME/WORK

_____
1st Contact Email 2nd Contact Email

Permission to send information by Email- Signature_____

_____ ☐
OTHER CHILD CARE PROVIDER NAME CELL NUMBER HOME/WORK

Other Emergency Contacts with Permission to Pick Up:

Name	Relationship to child	Daytime Phone/Cell Number	
			☐
			☐

Medical Information:

Family Doctor: _____
NAME PHONE NUMBER

Care Card number: _____

Child's Dentist: _____
NAME PHONE NUMBER

Is your child allergic to any foods/drinks, medications or have any medical conditions?

_____

_____

1. It is the policy of this facility to notify a parent when a child is ill or needs medical attention. Occasionally we cannot contact parents and we need to get immediate help for the child. Our procedure is to call for an ambulance.
2. Please sign the consent below so that we can take the appropriate action on behalf of your child. Return the signed consent to the facility immediately. We will take this consent with us to the emergency centre.
3. I hereby give consent for my child to be taken to the nearest emergency centre when I cannot be contacted.
4. I hereby give consent for my child named above to receive medical treatment.

Parent or Guardian Signature_____