CHILD CARE EMERGENCY CONTACT INFORMATION

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Child's Name: _____ Birthdate: _____

Parent/Guardian name # 1:_____

    Telephone numbers: Home: (   )_____ Work: (   ) _____

Parent/Guardian name # 2:_____

    Telephone numbers: Home: (   )_____ Work: (   ) _____

Emergency contacts to whom child may released if the parent/guardian is unavailable:

    Name & relationship #1 _____

    Telephone numbers: Home (   )_____ Work: (   ) _____

    Name & relationship #2 _____

    Telephone numbers: Home (   )_____ Work: (   ) _____

Child's Health care Provider:

    Name _____ Phone # (   ) _____

    Address _____

Child's Health Insurance:

    Name of insurance plan _____ ID # _____

    Subscriber's name on insurance card_____

List special conditions, disabilities, allergies or medical information for emergency situations:

_____

_____

_____

List preference for transport arrangement in an emergency situation (Parents/guardians are responsible for all emergency transportation charges.) :

Hospital preference 1st Choice_____ 2nd Choice _____

Parent/guardian Consent and agreement or emergencies:

As parent/guardian, I give consent to have my child _____

receive first aid by the child care staff, and, if necessary, be transported to receive emergency care. I also authorize the Director or Director Designee to contact to my child health care provider to alert him/her to my child's situation.

I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above to act on my behalf until I am available. I agree to review and update this information wherever a change and at least every 6 months.

Parent/Guardian Signature # 1:_____ Date _____

Parent/Guardian Signature # 2:_____ Date _____

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PARENTAL AUTHORIZED FOR EMERGENCY TREATMENT

CHILD'S NAME _____

Age _____ date of Birth _____

Address _____

PARENT(S) NAME_____

Parent(s) Address_____

CHILD'S MEDICAL INFORMATION

Medical Problems_____

Allergies _____

Medicine (s) Child is taking _____

Medicine (s) Child is Allergic to _____

Name of Child's Health care provider_____ Telephone _____

CHILD'S INSURANCE

Company/HMO _____

Group Number _____ identification # _____

I (we) state that we are the parent(s)/guardian(s) having legal custody of above child and attest that the information above is correct. I (we) authorize the above child care center director or director designee to obtain emergency treatment for my child. I consent to x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

The following steps will be followed in a n emergency:
 1. The parent/guardian will be contact immediately.
 2. The child's health care provider will be contacted.
 3. We will attempt to contact you or your child's health provider, we will do any or all of the following.
 4. If we cannot contact you or your child's health care provider, we will do any or all of the following.
    a) Call for emergency first aid assistance/transportation.
    b) Call another health care provider.
    c) Have the child transported to an emergency hospital in the company of the staff o member.

Parent Signature _____ Date _____

Witness Signature _____ Date _____

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