Emergency Contact Information

Child's Name: _____ Age: _____ D.O.B. _____/_____/_____ **SEX**: ☐ F ☐ M

Address: _____ _____ City: _____ State: _____ Zip: _____

Parents' Information:

Mother's Name: _____ Best Phone # (_____) _____ - _____

E-mail _____ Work Phone#: (_____) _____-_____ EXT. _____

Father's Name: _____ Best Phone # (_____) _____ - _____

E-mail _____ Work Phone#: (_____) _____-_____ EXT. _____

If parents or guardians cannot be reached in cases of emergency, illness, or accident, the following persons listed can be contacted and are authorized to remove my child from the center. If Parent/Guardian cannot be reached please notify:

Name: _____
Phone Numbers:
Home: (_____) _____-_____
Work: (_____) _____-_____
Cellular (_____) _____-_____

Name: _____
Phone Numbers:
Home: (_____) _____-_____
Work: (_____) _____-_____
Cellular (_____) _____-_____

The following people listed below are authorized to pick up/remove my child from CLC:

_____

_____

Please Note: Children are only released to custodial parents, legal guardians and authorized persons listed. Please understand, for the safety of the children, ALL authorized, familiar and unfamiliar pick up persons listed will be asked to show identification before a child is released from CLC.

MEDICAL INFORMATION/ PERMISSION FOR MEDICAL ATTENTION

Known allergies to medications & other substances: _____

Hospital Preference: _____

Physician's Name: _____ Phone Number: (____) _____-_____

Dentist's Name: _____ Phone Number: (____) _____-_____

In the event of an emergency:

I authorize the staff of Children's Learning Center to provide any first aid care deemed necessary for my child. ☐**Yes** ☐**No**

If I cannot be reached, the physician listed above and the local hospital are hereby authorized to provide any emergency care deemed necessary for my child. ☐**Yes** ☐**No**

I hereby authorize the transfer of my child's health records to the local hospital. ☐**Yes** ☐**No**

I agree that the operator may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately. ☐**Yes** ☐**No**

_____ _____

Parent's Signature Date