

EXTENDED CARE PROGRAM EMERGENCY INFORMATION

Child's Last Name

First Name

Home Address

Home Telephone Number

Birth Date

Mother's Name

Cell/Business #

Father's Name

Cell/Business #

IN THE EVENT OF A SERIOUS ILLNESS, ACCIDENT OR WHEN I CANNOT BE REACHED, ONE OF THE FOLLOWING MAY BE NOTIFIED. THEY ARE AUTHORIZED TO ACT IN MY ABSENCE. THEY MAY ALSO RELEASE MY CHILD FROM THE CENTER IF NEEDED.

NAME

TELEPHONE

NAME

TELEPHONE

NAME

TELEPHONE

NAME

TELEPHONE

IF ON THE ABOVE CANNOT BE REACHED, I WISH MY CHILD TO BE TAKEN TO THE EMERGENCY HOSPITAL. YES _____ NO _____

DOCTOR'S NAME

TELEPHONE

ADDRESS

ALLERGIES: _____

