2017-2018 Extended Care Program

Emergency Information Form

Family Last Name _____

Child First Name _____

Child First Name _____

Child First Name _____

Address _____ Home Phone _____

Father's Name _____ Contact Phone #_____

Mother's Name _____ Contact Phone # _____

Illness or Accident: In the event of an apparently serious illness or accident, when I cannot be reached, I wish one of the following to be notified by telephone. They are authorized to act in my absence. They may also pick up my child/children.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

The following person(s) MAY NOT pick up my child/children: _____

_____

If one of the above contacts cannot be reached, I wish my child to be taken to the hospital. _____ yes _____ no If yes, which hospital _____.

I wish any one of the following doctors to be notified:

Name _____ Phone _____

Name _____ Phone _____

Special Instructions (allergies, chronic illness, etc.) Please name child and condition

_____

_____