Capital Kids Preschool

Where Minds Grow

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H)_____(W)_____
   Last First

   Address _____

2. Name _____ Telephone (H)_____(W) _____
   Last First

   Address _____

3. Name _____ Telephone (H)_____(W) _____
   Last First

   Address _____

Child's Physician or Source of Health Care _____ Telephone _____

Address _____

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian_____Date _____

Child's Name _____ Birth Date _____

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____

Mother's Name _____ Home Telephone _____

Mother's Employer/School _____

Mother's Home Address (*If different from above)* _____

Work Telephone _____ Cellular Phone _____ _____

Father's Name _____ Home Telephone _____

Father's Employer/School _____

Father's Home Address *(If different from above)* _____

Work Telephone _____ Cellular Phone _____ _____

Name of Person Authorized to Pick Up Child *(daily)* _____
Last First Relationship to Child

Address _____

ANNUAL UPDATES _____ _____ _____ _____ _____
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

INSTRUCTIONS TO PARENT:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.

(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

_____

Medications currently being taken by your child: _____

_____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

_____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

_____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

_____

_____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

_____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

Name of Health Practitioner	Date
Signature of Health Practitioner	(_____) Telephone Number