

EMERGENCY CONTACT FORM

Please complete both sides of this form.

Child's Name: _____ Adult enrolling child: _____

MOTHER or LEGAL GUARDIAN: Primary party responsible for billing First Contact

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Home Phone #: _____ Cell Phone #: _____

Company/Employer Name: _____ Work Hours: _____

Address: _____ Work Phone #: _____

Email address: _____

FATHER or LEGAL GUARDIAN: Primary party responsible for billing First Contact

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Home Phone #: _____ Cell Phone #: _____ (if different from above)

Company/Employer Name: _____ Work Hours: _____

Address: _____ Work Phone #: _____

Email address for communications: _____

CHILD'S NAME:

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

Home Phone #: _____ Social Security #: X X-____ Date of Birth: _____

Gender: (circle) Male Female Ethnicity: _____

If someone referred you to us, please be sure to list that person here _____
Not referred? How did you hear about us? _____

EMERGENCY CONTACT/AUTHORIZED PICKUP PEOPLE:

Name: _____ Relationship to child: _____

Address: _____

Phone: _____ Second Phone: _____ Authorized to pick up: (circle) Y N

Name: _____ Relationship to child: _____

Address: _____

Phone: _____ Second Phone: _____ Authorized to pick up: (circle) Y N

Name: _____ Relationship to child: _____

Address: _____

Phone: _____ Second Phone: _____ Authorized to pick up: (circle) Y N

Physician: _____ Phone: _____

Address: _____

Dentist: _____ Phone: _____

Address: _____

Hospital Preference: _____ Phone: _____

Insurance Provider: _____ Policy #: _____

Health Assessment form on file: Yes No **Date Completed:** _____ **Expires:** _____

Allergies, Medical or Dietary Needs: _____

Specific care plan completed and on file for allergies, medical or dietary needs: YES NO

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT:

<p><u>Transportation for emergency purposes only:</u> X _____ (Parent signature) Special Instructions: _____</p> <p><u>Walks and Walking Field Trips (within 10 blocks)</u> X _____ (Parent Signature)</p>	<p><u>Administration of:</u></p> <p><input type="checkbox"/> Prescription Medications X _____ (Parent Signature)</p> <p><input type="checkbox"/> Minor First Aid X _____ (Parent Signature)</p> <p><input type="checkbox"/> Emergency Medical Care X _____ (Parent Signature)</p>
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Photo Release: I understand that my child/children may be photographed in group situations or individually during this program. I hereby give consent for such photos to be published in perpetuity within our mobile app, our social media pages, website, print publications, and for advertising, promotional and marketing purposes. *Nonconsenting parents/guardians for custody purposes should alert staff to this concern.

Parent/Guardian Signature

Date

Director Signature

Date

DO NOT COMPLETE UNLESS THERE ARE CHANGES TO INFORMATION PROVIDED IN THE FORM:

Parent Signature Changes? YES NO _____
Date

Parent Signature Changes? YES NO _____
Date