**EMERGENCY RECORD CARD**



**CHILD’S INFORMATION**

|  |  |
| --- | --- |
| **Last Name:** | Date of Birth: |
| **First Name:** | First Day in Care: |
| Siblings enrolled Yes No | Any Custody Arrangements? Yes No NA |

**NAMES OF PARENT(S) OR LEGAL GUARDIAN(S) CONTACT INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** | | **Relationship:** | **Name:** | | **Relationship:** |
| Place of Employment / Other: | | | Place of Employment / Other: | | |
| Phone: | | | Phone: | | |
| Physical Home Address: | | | Physical Home Address: | | |
| Cell Phone: ok to send text msg. | Home Phone: | | Cell Phone: ok to send text msg. | Home Phone: | |
| E-mail Address: | | | E-mail Address: | | |

**PERSONS AUTHORIZED TO PICK-UP CHILD – Emergency / Routine**

|  |  |  |  |
| --- | --- | --- | --- |
| List the names and phone numbers of persons who can pick up your child. You must include at least one name and phone number of an individual who can  assume responsibility for your child if you cannot be reached immediately in an emergency. Clarify whether these individuals can pick up the child in emergency situations only or at other routine times. Individuals cannot be under the age of 16. | | | |
| Name: | Daytime Phone: | Cell: | Emergency Routine |
| Name: | Daytime Phone: | Cell: | Emergency Routine |
| Name: | Daytime Phone: | Cell: | Emergency Routine |
| Name: | Daytime Phone: | Cell: | Emergency Routine |

**\*\*Signature of Parent or Legal Guardian and periodic updates required on reverse side of this form\*\***

**MEDICAL INFORMATION and RELEASE FOR MEDICAL CARE**

**Child’s Name: Child Care Facility:**

|  |  |
| --- | --- |
| **My child has NO ongoing health concerns**, including allergies or ongoing medications | |
| **- OR -** | |
| **My child has the following chronic health concerns:** allergies (list all): Asthma Diabetes Seizures or epilepsy Other (list):  My child takes the following ongoing medications: | |
| **PREFERRED MEDICAL FACILITY INFORMATION** | |
| Physician’s Name: | Physician’s Phone (recommended): |
| Preferred Hospital: Providence Regional ANMC JBER Other: | |

|  |  |  |
| --- | --- | --- |
| I, the parent or legal guardian of hereby give the above named facility permission to seek emergency medical treat understand that every effort will be made to locate me or my child’s other parent o  child care provider informed of my whereabouts. I will assume the cost of necess | , am veri ment, including  r legal guardian  ary medical or s | fying that this medical information is correct and complete. I  necessary emergency paramedic transport for my child. I  as soon as possible. I understand my obligation to keep my urgical care and any related medical transportation costs. |
| **Signature of Parent or Legal Guardian** | **Date Signed** |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Information on this Emergency Record Card must be Reviewed and Updated Semi-annually*** | | | | | | | | | |
| **Date & Initial** | | **Date & Initial** | | **Date & Initial** | | **Date & Initial** | | **Date & Initial** | |
|  |  |  |  |  |  |  |  |  |  |

F-Emergency Record Card 12-12-11