Beth El
Early Learning Center

EMERGENCY CONTACT FORM
2018-2019

STUDENT'S LAST NAME | FIRST NAME | NICKNAME | SEX | BIRTH DATE

ADDRESS | CITY | ZIP

HOME PHONE | CELL PHONE PARENT 1 | CELL PHONE PARENT 2

E-MAIL PARENT 1 | E-MAIL PARENT 2

PARENT 1 _____ WORK PHONE _____

PARENT 2 _____ WORK PHONE_____

PEDIATRICIAN _____ PHONE _____

ALTERNATIVE CONTACTS IN CASE OF EMERGENCY

Name _____ Phone _____ Relationship_____

Name _____ Phone _____ Relationship_____

HEALTH INSURANCE INFORMATION

Insurance Company Name _____

Phone Number _____ Policy Number _____

SPECIAL MEDICAL PROBLEMS, CHRONIC CONDITIONS, ETC.

_____

ALLERGIES (DRUGS, FOOD, INSECT BITES, ETC.)

_____

MEDICATIONS TAKEN REGULARLY

Name of Medication _____ Reason Taken _____ Dose & Frequency_____

HOSPITALIZATIONS, SURGERIES, MAJOR INJURIES

Nature | Date | Doctor

_____

TREATMENT RELEASE

In the event of a medical emergency involving my child _____ when neither parent can be contacted, I hereby give permission for the School Director or the child's teacher to authorize emergency treatment and release the information given above.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____