Emergency Contact Information - High Scope Learning Care

Child Name/s

Child Date Of Birth

Month Day Year

Legal Guardian #1

First Name Last Name

Address

Street Address

City State

Zip Code

Phone Number 1

Please enter a valid phone number.

Phone Number 2

Area Code Phone Number

Company Name

Address

Legal Guardian #2

First Name Last Name

Address

Street Address

State

City

Zip Code

Company Name

Address

If above persons are not available: Name and addresses of persons to be contacted and to whom the child may be released (must give three contacts):

Name

First Name Last Name

Relationship

Address

Phone Number

Name

First Name Last Name

Relationship

Address

Phone Number

Name

First Name Last Name

Relationship

Address

Phone Number

Child's Usual Source of Medical Care

First Name Last Name

Phone Number

Address

Insurance Plan

Child Health Card Number

Subscriber's Name (on Insurance card):

Secondary Insurance (if any)

Hospital You Prefer

Child's Usual Source of Dental Care

First Name Last Name

Phone

Address

Parents Consent: If, at any time, due to such circumstances as accident, sudden illness, or emergency and medical treatment is required, this may be given, including anesthetic, if necessary, by a private physician or hospital. Specific Instructions Of Parent/Guardian (i.e. Allergies, ongoing medication, restrictions for treatment, etc.):

Are there any known special conditions, allergies, health or medical conditions that the provider should be made aware of? If Yes, please describe

Transport Arrangement in an Emergency Situation: Ambulance Service preference:

Signature

Date

Month Day Year

Parents/Legal Guardian Consent and Agreement for Emergencies

I/We _____ _____ hereby give my/our permission to

First Name Last Name

Daycare Name

_____ to call a doctor for medical or surgical care for my/our child,

Child Name/s

_____

receive first aid and emergency medical treatment by emergency personnel, and to be transported to receieve emergency care, if necessary. I understand that I will be responsible for all charges not covered by Insurance. I give consent for the emergency contact person listed above to act on my behalf until I am available. I agree to reveiw and update this information whenever a change occurs and at least every once a year.

Note: It is desirable, when possible, to have these signatures attested by a Notary Public when granting emergency medical authorization.

Parent/Guardian's Signature

_____

Date

___ ___ ___

Month Day Year

Parent/Guardian's Signature

_____

Date

___ ___ ___

Month Day Year