

CASE/CONCORD CHILD DEVELOPMENT CENTER
EMERGENCY CARD

CHILD'S NAME _____ DOB _____ GENDER _____
PARENT'S NAME _____
HOME ADDRESS _____
MAILING ADDRESS _____
HOME PHONE _____ CELL _____
MOTHER'S EMPLOYER _____ PHONE _____
FATHER'S EMPLOYER _____ PHONE _____

PERSONS OTHER THAN PARENTS WHO MAY BE CALLED IN CASE OF AN EMERGENCY

NAME _____ RELATION _____ PHONE _____
NAME _____ RELATION _____ PHONE _____

PERSONS OTHER THAN PARENTS AUTHORIZED TO PICK UP YOUR CHILD FROM THE CENTER. (I.D. REQUIRED)

NAME/ADDRESS _____
RELATION _____ PHONE _____
NAME/ADDRESS _____
RELATION _____ PHONE _____
NAME/ADDRESS _____
RELATION _____ PHONE _____

IF SCHOOL AGE, WHAT SCHOOL DO THEY ATTEND _____
PHONE _____ TEACHER'S NAME _____

CASE/CONCORD CHILD DEVELOPMENT CENTER
EMERGENCY CARD

CHILD'S NAME _____ DOB _____ GENDER _____
PARENT'S NAME _____
HOME ADDRESS _____
MAILING ADDRESS _____
HOME PHONE _____ CELL _____
MOTHER'S EMPLOYER _____ PHONE _____
FATHER'S EMPLOYER _____ PHONE _____

PERSONS OTHER THAN PARENTS WHO MAY BE CALLED IN CASE OF AN EMERGENCY

NAME _____ RELATION _____ PHONE _____
NAME _____ RELATION _____ PHONE _____

PERSONS OTHER THAN PARENTS AUTHORIZED TO PICK UP YOUR CHILD FROM THE CENTER. (I.D. REQUIRED)

NAME/ADDRESS _____
RELATION _____ PHONE _____
NAME/ADDRESS _____
RELATION _____ PHONE _____
NAME/ADDRESS _____
RELATION _____ PHONE _____

IF SCHOOL AGE, WHAT SCHOOL DO THEY ATTEND _____
PHONE _____ TEACHER'S NAME _____

PHYSICIAN'S NAME _____ PHONE _____
ADDRESS _____
DENTIST'S NAME _____ PHONE _____
ADDRESS _____
HOSPITAL PREFERRED _____
HEALTH INSURANCE COMPANY _____ PHONE _____
ADDRESS _____ POLICY # _____
ONGOING MEDICATIONS _____
ALLERGIES _____

I GIVE PERMISSION TO ADMINISTER EMERGENCY MEDICAL TREATMENT TO MY CHILD AND TO TRANSPORT TO THE
NEAREST MEDICAL FACILITY. YES NO (CIRCLE ONE)
I GIVE PERMISSION FOR MY CHILD TO BE VIDEO AND/OR AUDIO TAPED AND/OR PHOTOGRAPHED. YES NO

PARENT'S SIGNATURE

DATE

PLEASE HAVE THIS NOTORIZED BELOW

PHYSICIAN'S NAME _____ PHONE _____
ADDRESS _____
DENTIST'S NAME _____ PHONE _____
ADDRESS _____
HOSPITAL PREFERRED _____
HEALTH INSURANCE COMPANY _____ PHONE _____
ADDRESS _____ POLICY # _____
ONGOING MEDICATIONS _____
ALLERGIES _____

I GIVE PERMISSION TO ADMINISTER EMERGENCY MEDICAL TREATMENT TO MY CHILD AND TO TRANSPORT TO THE
NEAREST MEDICAL FACILITY. YES NO (CIRCLE ONE)
I GIVE PERMISSION FOR MY CHILD TO BE VIDEO AND/OR AUDIO TAPED AND/OR PHOTOGRAPHED. YES NO

PARENT'S SIGNATURE

DATE

PLEASE HAVE THIS NOTORIZED BELOW