Emergency Contact Information for:

Child's Name:________________________ Date of Birth:__________ Food Allergies:__________________________

Mother's Name and Address:____

Mother's Home/Cell Number:________________________ Mother's Work Number:_____________________________

Father's Name and Address:____

Father's Home/Cell Number:_________________________ Father's Work Number:____________________________

Emergency Contact 1:_______________________________Home/Cell Number:________________________________

Emergency Contact 2:_______________________________Home/Cell Number:________________________________

Person's Authorized to pick-up child:

1.______________________________________ 2. ____

3. ____

Child's Medical Information

Allergies:____

Daily Medications:____

Health/Behavioral Concerns:____

Doctor's Name and Number: ____

Preferred Hospital: ____

I understand that I will be notified at once in case of accident or illness to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice. If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I herby authorize ***St. Philip's Early Childhood Center*** **to do so.**

____ ____________________________________

Parents' Signature Date