ST. ALBAN'S EARLY CHILDHOOD CENTER - EMERGENCY CARD

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this form. Sign and date where indicated.
(2) If your child has a medical condition including allergies, complete the bottom of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY

Child's Name _____ Birth Date _____

Home Address _____
Street/Apt# City State Zip Code

Parent/Guardian Name _____ Home Telephone _____

Employer/School _____
Name Address

Work Telephone _____ Cellular Phone _____

Parent/Guardian Name _____ Home Telephone _____

Employer/School _____
Name Address

Work Telephone _____ Cellular Phone _____

When parents cannot be reached, list at least two people who may be contacted to pick up the child in an emergency.

1. Name _____ Telephone Numbers (H) _____

   (W) _____ (Cell) _____ Beeper _____

2. Name _____ Telephone Numbers (H) _____

   (W) _____ (Cell) _____ Beeper _____

3. Name _____ Telephone Numbers (H) _____

   (W) _____ (Cell) _____ Beeper _____

Name of Person(s) Authorized to Pick Up Child (Daily)

Name _____ Relationship to Child_____

Telephone Number (H) _____ (W)_____ (C) _____

Name _____ Relationship to Child_____

Telephone Number (H) _____ (W)_____ (C) _____

Child's Physician or Source of Health Care _____ Telephone_____

Address _____
Street/Apt# City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

_____ _____
Signature of Parent/Guardian Date

ALLERGIES_____

ANNUAL UPDATES _____ _____ _____ _____
(INITIALS/DATE) (INITIALS/DATE) (INITIALS/DATE) (INITIALS/DATE)

PHYSICIAN NAME _____ **PHYSICIAN PHONE NUMBER**_____