

EMERGENCY CONTACT FORM

Student Name: _____ Teacher: _____
Address: _____ ZIP: _____
Date of Birth: _____ Class Days: _____
Allergies, Chronic Illnesses, Special Needs: _____

Please be specific for the following required information. In case of illness, an accident, or an emergency, it is necessary for the school to know your preferences for the care of your child.

Parent/Guardian :

Name: _____ Home Phone: _____
Home Address: _____ Cell phone: _____
City: _____ Zip: _____
Place of Employment: _____

Employment Address: _____ City: _____ Zip: _____
Business Phone: _____

Parent/Guardian :

Name: _____ Home Phone: _____
Home Address: _____ Cell phone: _____
City: _____ Zip: _____
Place of Employment: _____

Employment Address: _____ City: _____ Zip: _____
Business Phone: _____

Special instructions on how parents/guardians may be reached during the hours my child is in school: _____

PHYSICIAN: _____ Phone: _____
PHYSICIAN ADDRESS: _____
DENTIST: _____ Phone: _____
DENTIST ADDRESS: _____
HOSPITAL OF CHOICE: _____ Phone: _____
HOSPITAL ADDRESS: _____

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Emergency contacts who can assume responsibility (including authorization for pick up) for your child in the event parents or guardians cannot be reached! If these contacts are unknown to our staff, they must present a photo ID.

Emergency Contact :

Name: _____ Relationship to Child: _____
Home Phone: _____ Cell phone: _____
Home Address: _____ City: _____ Zip: _____

Emergency Contact :

Name: _____ Relationship to Child: _____
Home Phone: _____ Cell phone: _____
Home Address: _____ City: _____ Zip: _____

The following adults (16 years of age or older) have my permission to pick up my child from school. A photo ID must be presented.

Authorized Adult :

Name: _____ Relationship to Child: _____
Home Phone: _____ Cell phone: _____
Home Address: _____ City: _____ Zip: _____

Authorized Adult :

Name: _____ Relationship to Child: _____
Home Phone: _____ Cell phone: _____
Home Address: _____ City: _____ Zip: _____

Authorized Adult :

Name: _____ Relationship to Child: _____
Home Phone: _____ Cell phone: _____
Home Address: _____ City: _____ Zip: _____

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Authorization for emergency medical care and transportation:

In the event of an emergency, I hereby give my permission for Montview Community Preschool & Kindergarten staff to access emergency medical services for my child or children, including transport to the nearest health care facility to receive emergency medical or surgical care and treatment. It is understood that a conscientious effort will be made to locate me, and I accept the expense of care and transport.

Parent/Guardian Signature

Date

Parent/Guardian Signature *

Date

*** Two signatures are required in two parent/guardian households.**