Emergency Contact & Authorization Form

Child's Name:____ Date of Birth:_______________

Child's address: ____

Child resides with: ☐ Mother ☐ Father ☐ Both parents ☐ Guardian

Guardian 1	Guardian 2
Guardian 1: _________________________________	Guardian 2: _________________________________
Relationship to child: _________________________	Relationship to child: _________________________
Address: ☐ Same as Child or below	Address: ☐ Same as Child or below
____	____
____	____
Home/Cell: _________________________________	Home/Cell: _________________________________
Work: _____________________________________	Work: _____________________________________
Best # to contact ☐ home/cell ☐Work	Best # to contact ☐ home/cell ☐Work

Emergency Contact Persons: 2 are required by state licensing guidelines

Name:____ Relationship to child: _________________________
Address:____
Home/cell: _____________________________________ Work:_______________________________________
☐ Emergency Contact Only ☐Emergency Contact AND release

Name:____ Relationship to child: _________________________
Address:____
Home/cell: _____________________________________ Work:_______________________________________
☐ Emergency Contact Only ☐Emergency Contact AND release

Name:____ Relationship to child: _________________________
Address:____
Home/cell: _____________________________________ Work:_______________________________________
☐ Emergency Contact Only ☐Emergency Contact AND release

Medical and Dental Information:

Physician Name & Clinic: ______________________________________ Phone:____________________________
Clinic Address :____
Insurance Company:____________________________________ Policy ID: ______________________________
Preferred Hospital: ____Date of Last TDAP __________________
Allergies:____
Special Health Conditions/instructions: ____
____
Current Medications:____
Dentist & Clinic: ____ Phone:____________________________
Clinic Address:____
Insurance Company:____________________________________ Policy ID: ______________________________

I/We ____________________________________authorize Children of Hope Preschool Staff to take whatever emergency medical measures deemed necessary for the care and protection of my child. I understand that this may involve calling 911 and may involve transporting my child to ____________________ hospital. (Please list the hospital of your choice). I understand I will be notified as soon as possible. I assume the financial responsibility fully for acts by Children of Hope and medical professionals if such a situation should arise.

Guardian 1 Signature: ____ Date:______________________

Guardian 1 Signature: ____ Date:______________________