EMERGENCY CONTACT FORM

CHILD'S NAME________________________ BIRTHDATE_______________PHONE___________________

In each scenario below, please indicate the NAME, RELATIONSHIP, and PHONE NUMBER of persons to be contacted. (Include yourself if appropriate). We will phone IN THE ORDER LISTED. Please update during the year if necessary.

1**) LATE "PARENTAL" PICK-UP**:

NAME/RELATIONSHIP____ PHONE #______________

NAME/RELATIONSHIP____ PHONE #______________

NAME/RELATIONSHIP____ PHONE #______________

2) **CHILD BECOMES ILL AT SCHOOL AND NEEDS TO GO "HOME". AT LEAST ONE CONTACT MUST BE AVAILABLE TO PICK UP CHILD WITHIN ½ HOUR OF BECOMING ILL.**

____Same as above or

NAME/RELATIONSHIP____ PHONE #______________

NAME/RELATIONSHIP____ PHONE #______________

NAME/RELATIONSHIP____ PHONE #______________

3) **IF A MEDICAL EMERGENCY OCCURS AT SCHOOL**:

911 will be called
parents will be notified

CHILD'S DOCTOR:____________________________________ PHONE NUMBER_______________

ALLERGIES:

4) EMERGENCY TREATMENT RELEASE FORM:

I give permission for the staff of Great Beginnings to authorize emergency medical treatment of my child_____________________if I cannot be reached. (2021-2022 School Year)

SIGNED____ DATE_________________

Mom's phone number(s)____

Dad's phone number(s)____ 2021/2022