

**EMERGENCY CONTACT & ALTERNATE PICK-UP INFORMATION
2024-2025**

CHILD INFORMATION

Child's Name: _____ Date of Birth: _____
 Child's Home Address: _____ Home Phone: _____
 Classroom: _____ Gender: _____ Eye Color: _____ HairColor: _____
 Primary Language: _____ Height: _____ Weight: _____ Ethnicity: _____
 Identifying Marks: _____

PARENT CONTACT INFORMATION

Parent/Guardian Name: _____ Day/Cell Phone: _____
 Home Address: _____
 Work/School Dept. & Address: _____
 Email Address: _____
 Parent/Guardian Name: _____ Day/Cell Phone: _____
 Home Address: _____
 Work/School Dept. & Address: _____
 Email Address: _____

CHILD'S MEDICAL INFORMATION

_____ Special Care Plan on File: _____
(list condition(s) plan is for)

___ Allergy:

___ Other medical concerns/conditions:

___ Medication:

___ Dietary restriction:

___ Food Intolerance:

Pediatrician: _____ Phone No.: _____

Address: _____ Medical Insurance Carrier: _____

EMERGENCY CONTACT INFORMATION (Alternatives to parents/guardians listed above)

CEEC may contact and release my child to the following person in case of an emergency when I am not available.

Name _____ Phone: _____ Relationship to Child _____

In addition to the above contact, I give permission for my child to be released to the person(s) listed below.

Name _____ Phone: _____ Relationship to Child _____

Name _____ Phone: _____ Relationship to Child _____

Name _____ Phone: _____ Relationship to Child _____

Name _____ Phone: _____ Relationship to Child _____

Name _____ Phone: _____ Relationship to Child _____

In the event emergency medical treatment is required I give consent for my child to be transported to a nearby medical facility to receive treatment by a qualified physician.

Signature of Parent/Guardian: _____ Date: _____

EMERGENCY CONTACT INFORMATION CONTINUED

Name _____ Phone: _____ Relationship to Child _____

Name _____ Phone: _____ Relationship to Child _____

Name _____ Phone: _____ Relationship to Child _____

Signature of Parent/Guardian: _____ Date: _____