

Child Care Center Emergency Card

FORM 3665X 8/94

PUPIL'S NAME: (LAST)		BIRTHDATE		SEX
PARENT'S NAME (OR LEGAL GUARDIAN):				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
FATHER	MOTHER			MARITAL STATUS
HOME ADDRESS	CITY	ZIPCODE	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	
FATHER'S BUSINESS NAME / ADDRESS	CITY	ZIPCODE	TELEPHONE NUMBER	
MOTHER'S BUSINESS NAME / ADDRESS	CITY	ZIPCODE	TELEPHONE NUMBER	
DOCTOR'S NAME / ADDRESS			TELEPHONE NUMBER	
DENTIST'S NAME / ADDRESS			TELEPHONE NUMBER	

UNUSUAL HEALTH CONDITION IF YES, PLEASE INDICATE BELOW: OTHER: _____

YES NO DIABETES HEART SEIZURE DISORDER ALLERGY ASTHMA

RECOMMENDED TREATMENT OR MEDICATION _____

PHYSICAL RESTRICTIONS _____

LIST ANY ILLNESS OCCURRING IN THE PAST YEAR _____

Relative or Neighbor to be called in the case of Emergency when parents cannot be reached:

NAME / RELATIONSHIP	CITY	ZIPCODE	TELEPHONE NUMBER
NAME / RELATIONSHIP	CITY	ZIPCODE	TELEPHONE NUMBER

If emergency treatment is required and the parents cannot be reached immediately, may the Child Care Center authorities use their judgement in calling the doctor or dentist indicated above or if not available an alternate doctor or dentist? Check Yes No. If "No", what do the parents want done? _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____