CHILD EMERGENCY CONTACT FORM
UNIVERSITY UNITED METHODIST DAY SCHOOL
2020-2021

Place Allergy Label Here (Office Use Only)

(Please use black or blue ink only)

CHILD'S FIRST & LAST NAME ____

PARENTS' NAMES ______________________________ PARENT E-MAIL ______________________

ADDRESS ________________________________ CITY __________________ ZIP _____________

IMPORTANT PHONE NUMBERS:

MOTHER-HOME ______________ WORK _________________ CELL ___________________

FATHER-HOME _______________ WORK ________________ CELL ___________________

CHILD'S BIRTH DATE _______________ TEACHER'S NAME ___________________________________
(for office use only)

DAYS YOUR CHILD ATTENDS SCHOOL MWF T/Th WF M-F

NAMES OF PEOPLE WHO ARE AUTHORIZED TO PICK UP YOUR CHILD, INCLUDING CAR POOL:

NAME	RELATIONSHIP	ADDRESS	PHONE	CELL

PERSON TO CALL WHEN **PARENT CANNOT BE REACHED** TO PICK UP YOUR CHILD IN THE EVENT OF ILLNESS OR EMERGENCY:

NAME	RELATIONSHIP	ADDRESS	PHONE	CELL

IS THERE ANYONE WHO **MAY NOT** PICK UP YOUR CHILD?
TO ENFORCE THIS REQUEST, A COURT DOCUMENT **MUST** BE FILED IN THE DAY SCHOOL OFFICE

____

PLEASE COMPLETE REVERSE SIDE

SPECIAL CARE NEEDS

DOES YOUR CHILD RECEIVE ANY SPECIAL SERVICES? ___________________________________

IF YES, WHAT SERVICES? ____

ALLERGIES

____

EXISTING ILLNESSES/MEDICAL CONDITION

____

HOSPITALIZATIONS WITHIN THE PAST TWELVE MONTHS ________________________________

PREVIOUS SERIOUS ILLNESS AND INJURIES

____

MEDICATIONS PRESCRIBED FOR DAILY OR LONG TERM USE _____________________________

WILL YOU HAVE A SPECIAL HEALTH NEEDS FORM AND MEDICATION ON FILE WITH THE OFFICE?

(THIS IS A MUST FOR: ANY MEDICATIONS ADMINSITERED AT SCHOOL ON A REGULAR BASIS OR FOR ASTHMA OR MEDICATIONS FOR ALLERGIC REACTIONS SUCH AS AN EPIPEN)

☐ **YES** ☐ **NO**

EMERGENCY CARE INFORMATION

PHYSICIAN'S NAME ____

PHYSICIAN'S PHONE NUMBER ____

PHYSICIAN'S ADDRESS ____

HOSPITAL PREFERENCE ____

INSURANCE CARRIER:____(if possible attach a copy)

POLICY#_______________________________________GROUP#_____________________________

POLICY IS IN THE NAME OF:____

IN THE EVENT THAT I CANNOT BE REACHED TO MAKE ARRANGEMENTS FOR EMERGENCY MEDICAL ATTENTION AT THE TIME OF AN ILLNESS OR ACCIDENT, I HEREBY AUTHORIZE THE UNIVERSITY UNITED METHODIST DAY SCHOOL DIRECTOR, PERSON IN CHARGE OR EMS TO TAKE MY CHILD TO THE PHYSICIAN AND/OR HOSPITAL NAMED ABOVE.

PARENT SIGNATURE ____ **DATE** _________________

PLEASE COMPLETE REVERSE SIDE