

EMERGENCY CONTACT INFORMATION



CHILD'S NAME (LAST, FIRST, MI)			CHILD'S DATE OF BIRTH		CHILD'S AGE		
ADDRESS			TELEPHONE		DATE ENROLLED IN CARE		
CITY, STATE, ZIP CODE			EMAIL ADDRESS				
DAYS/HOURS OF ATTENDANCE <input type="checkbox"/> Monday _____ to _____ <input type="checkbox"/> Tuesday _____ to _____ <input type="checkbox"/> Wednesday _____ to _____ <input type="checkbox"/> Thursday _____ to _____ <input type="checkbox"/> Friday _____ to _____							
PARENT INFORMATION		PARENT/GUARDIAN			PARENT/GUARDIAN		
NAME							
HOME ADDRESS							
PLACE OF EMPLOYMENT							
ADDRESS OF EMPLOYMENT							
CONTACT INFORMATION		HOME	CELL		HOME	CELL	
		WORK	EMAIL		WORK	EMAIL	
RESPONSIBLE FRIEND/RELATIVE TO CALL IF PARENTS CANNOT BE REACHED (MUST HAVE TWO)							
NAME			NAME				
ADDRESS			ADDRESS				
TELEPHONE		RELATIONSHIP		TELEPHONE		RELATIONSHIP	
ALL PERSONS AUTHORIZED TO REMOVE CHILD FROM THE CENTER							
NAME		RELATIONSHIP		NAME		RELATIONSHIP	
NAME		RELATIONSHIP		NAME		RELATIONSHIP	
EMERGENCY CONTACTS		MEDICAL			DENTAL (Required for ALL ages)		
NAME		PHYSICIAN			DENTIST		
ADDRESS							
TELEPHONE							
NAME OF INSURANCE COMPANY							
CONTRACT #							
IF UNAVAILABLE		ANOTHER LICENSED PHYSICIAN MAY TREAT MY CHILD		YES	NO	ANOTHER LICENSED DENTIST MAY TREAT MY CHILD	
PERMISSIONS		AUTHORIZATION IS HEREBY GIVEN TO CORNERSTONE PRESCHOOL AND CHILDCARE TO OBTAIN EMERGENCY MEDICAL CARE OR TREATMENT IN THE EVENT OF AN EMERGENCY				YES	NO
		AUTHORIZATION IS HEREBY GIVEN TO CORNERSTONE PRESCHOOL AND CHILDCARE TO PROVIDE TRANSPORTATION TO MY CHILD				YES	NO
SPECIAL CONDITIONS							
SPECIAL DIET, SPECIAL NEEDS, ALLERGIES, ETC.							

AUTHORIZATION: WE THE UNDERSIGNED HEREBY AGREE TO ABIDE BY TE ARRANGEMENTS AND AURTHORIZATIONS SO STATED ABOVE.

SIGNATURE OF PROVIDER	DATE	SIGNATURE OF PARENT/GUARDIAN	DATE
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