

## EMERGENCY CONTACT FORM

CHILD'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

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MOTHER'S NAME/LEGAL GUARDIAN: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_

BUSINESS NAME: \_\_\_\_\_ BUSINESS PHONE NUMBER: \_\_\_\_\_  
BUSINESS ADDRESS: \_\_\_\_\_

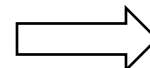
FATHER'S NAME/LEGAL GUARDIAN: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_

BUSINESS NAME: \_\_\_\_\_ BUSINESS PHONE NUMBER: \_\_\_\_\_  
BUSINESS ADDRESS: \_\_\_\_\_

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### EMERGENCY CONTACT PERSONS – IF UNABLE TO REACH LEGAL GUARDIANS:

NAME	ADDRESS	RELATIONSHIP TO CHILD	PHONE NUMBER



# Blessed Beginnings Preschool and Childcare LLC

DISABILITIES (IF ANY): \_\_\_\_\_

ALLERGIES (PLEASE LIST MEDICATIONS): \_\_\_\_\_

MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION:  
\_\_\_\_\_

MEDICATION – SPECIAL CONDITIONS: \_\_\_\_\_

ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD (PLEASE PROVIDE A COPY OF YOUR CHILD'S IFSP/IEP TO ADMIN):  
\_\_\_\_\_

NAME OF CHILD'S PHYSICIAN: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HEALTH INSURANCE COVERAGE FOR CHILD/MEDICAL ASSISTANCE BENEFITS: \_\_\_\_\_

POLICY NUMBER (REQUIRED): \_\_\_\_\_

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## PARENT SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT:

OBTAINING EMERGENCY MEDICAL CARE/TRANSPORT: \_\_\_\_\_

ADMIN. OF MINOR 1<sup>ST</sup> AID PROCEDURES: \_\_\_\_\_

WALKS AND STROLLER RIDES: \_\_\_\_\_

TRANSPORTATION BY THE FACILITY: \_\_\_\_\_

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BI-ANNUAL TIME PERIOD COVERED: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

BI-ANNUAL TIME PERIOD COVERED: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
ADMINISTRATOR SIGNATURE

\_\_\_\_\_  
DATE