SUNOL GLEN EAGLE'S NEST EMERGENCY CONTACT FORM: Yr _____

Each child needs their own Emergency Form

CHILDS NAME: _____DOB_____

Address _____

City Zip Code

Parent/Guardian 1

Name: _____

Last First

Address: _____

City: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Employer: _____

City: _____

Parent/Guardian 2

Name: _____

Last First

Address: _____

City: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Employer: _____

City: _____

Allergies: _____

Reactions: _____

Treatment: _____

_____

Other conditions: _____

May we apply antiseptic on your child's minor injury if needed? (circle) Yes / No

Does the child have diet restrictions? _____

Languages spoken at home: _____

Additional Persons who may be called in an emergency and are authorized to take your child from Eagle's Nest Childcare. Please indicate priority for emergency calls by order of listing.

(1) Name: _____ Relationship: _____

Address: _____ Phone: _____

(2) Name: _____ Relationship: _____

Address: _____ Phone: _____

(3) Name: _____ Relationship: _____

Address: _____ Phone: _____

PHYSICIAN AND DENTIST TO BE CALLED IN AN EMERGENCY

Physician:_____ Phone:_____

Address: _____

Medical Plan: _____ ID # _____

Dentist: _____ Phone: _____

Address: _____

Dental Plan: _____ ID # _____

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

Please indicate: _____ Call 911 _____ Other: _____

Does your child get motion/car sickness? _____

As the parent/legal guardian, I give consent to Sunol Glen staff members to obtain all emergency medical/dental care prescribed by a duly licensed physician (MD), Osteopath (DO) or Dentist (DDS) for my child. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my child.

Please give us any additional information that you feel may be helpful.

_____

_____

_____

_____

_____

Parent Signature_____ Date_____