Emergency Card

Child's Name: ______________________________ DOB: ____________ ☐ Male ☐ Female

Primary Address: ____

Street Address City, State Zip

Name	Mother:	Father:
Home Address	Street: City, State, Zip:	Street: City, State, Zip:
Home Phone		
Cell Phone		
E-mail Address		
Occupation		
Work Address	Name: Street: City, State, Zip:	Name: Street: City, State, Zip:
Work Phone		

Who will regularly pick up your child? ____________________________ ________________________

Name Name

Normal Drop Off Time __________AM or PM Pick Up Time _________ AM or PM

Is anyone legally restricted from picking up your child? _______ ______________________________

If yes, paperwork must be on file at the center. **Yes/No** **Name**

In the event of a medical emergency, who should be contacted first? ________**MOM** ________**DAD**

Of the contact numbers above, which one would you prefer the Center to call first? ____________________

List three alternate emergency contacts who have permission to pick up your child:

Name	Address	Phone
Name: Relationship:	**Street:** **City, State, Zip:**	**(H)** **(W/C)**
Name: Relationship:	**Street:** **City, State, Zip:**	**(H)** **(W/C)**
Name: Relationship:	**Street:** **City, State, Zip:**	**(H)** **(W/C)**

Does your child have any known allergies? _____ **No** _____ **Yes**

If yes, please list: ____

Does your child have any medical conditions? _____ **No** _____ **Yes**

If yes, please explain: ____

Does your child take regular medications? _____ **No** _____ **Yes**

If yes, name and frequency: ____

name and frequency: ____

Does your child see any specialists? _____ **No** _____ **Yes**

If yes, name and specialty: ____

Physician (Required)	**Name:**	**Street:** **City, State, Zip:**	**Phone:**
Dentist (Required)	**Name:**	**Street:** **City, State, Zip**	**Phone:**

In the event my child requires medical attention, I authorize the necessary medical professionals to administer all services required for my child's well being.

Insurance Co:______________________ **Group #:**____________________ **Member #:**____________

Signed: _________________________ **Date:** __________

Please continue to back ------->

CHEERS School Family
Permission for Medical Treatment and Transportation

I, ______________________, give my permission for Heritage Child Development
Name of Parent or Guardian
Center to consent for _________________________ to receive emergency medical,
Name of Child
dental or surgical treatment if I cannot be reached.

I place the following restrictions on medical treatment:

____

____

____

____

I (☐give) (☐do not give) permission for Heritage Child Development Center to contact the appropriate medical transportation facility to transport my child, __________,
Name of Child
to the closest medical facility.

I place the following restrictions on treatment:

____

____

____

____

_____________________________ Parent Signature

_______________ Date