EMERGENCY INFORMATION RECORD

Child's last name:

Child's first name:

Parent/Person(s) legally responsible:

Home phone: cell:

Address:

City:

State:

Zip:

Mother's business, address, phone:

Father's business, address, phone

In case of emergency and parent is not available, contact:

1. _____
(name) *(address)* *(phone)*

2. _____
(name) *(address)* *(phone)*

Student's Physician:

Address:

Phone:

Student's Dentist:

Address:

Phone:

Hospital where student should be taken if parent or physician is unavailable:

Address:

Insurance Co. and policy number:

Allergies and other medical conditions: (please explain checked items below or, if necessary, use other side of card:

_____Allergies _____Asthma _____Diabetes _____ Other

_____Epilepsy _____Heart problems _____Recurring illness

I authorize L.A.C. Preschool Staff (Administrators/Child's Teacher) and persons named above to obtain emergency treatment and access to my child's health records.

Signature of parent or person(s) legally responsible:

Date