St. John's
Early Learning Center
"Where children develop a love of learning."

CHILD EMERGENCY CARD

NAME: _____ CELL #: _____
Last First Middle

ADDRESS: _____
Street Town State Zip Code

BIRTHDAY: _____ MALE: _____ FEMALE: _____
Month Day Year

LIVES WITH: Mother: ____ Father: _____ Other: (specify) _____

To Parent / Guardian: In case of accident or illness at school, we need the following contact information:

FATHER: _____ PHONE: _____
Name Occupation / Address

MOTHER: _____ PHONE: _____
Name Occupation / Address

NAME AND PHONE NUMBERS OF ONE OR TWO ADULTS WE MAY CALL IF YOU ARE NOT AVAILABLE

_____ Relationship _____

_____ Relationship _____

HEALTH CONCERNS: Specify and explain fully (include chronic conditions, limitations, medications, special needs, etc)

Wears Glasses: _____ Wears Contacts: _____

DOCTOR: _____
Name Telephone Hospital

I do hereby authorize officials of the Children's Center to contact directly the persons named on this card, and do authorize the named physician or his / her associates to render such treatment as may be deemed necessary in an emergency for the health of said child. In the event that parents or guardians or other persons named on this card cannot be reached, the Children's Center officials are hereby authorized to take whatever actions are deemed necessary in their judgment for the health of the aforesaid child.

I HAVE READ THIS CARD AND AGREE TO THE STATEMENT AS IT IS WRITTEN:

DATE: _____ SIGNATURE OF PARENT / GUARDIAN: _____