

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

- (1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name Last First Birth Date

Enrollment Date Hours & Days of Expected Attendance

Child's Home Address Street/Apt. # City State Zip Code

Table with 3 main columns: Parent/Guardian Name(s), Relationship, Phone Number(s). Sub-columns for Place of Employment, C, and H.

Name of Person Authorized to Pick up Child (daily) Last First Relationship to Child

Address Street/Apt. # City State Zip Code

Any Changes/Additional Information

ANNUAL UPDATES

(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name Last First Telephone (H) (W)

Address Street/Apt. # City State Zip Code

2. Name Last First Telephone (H) (W)

Address Street/Apt. # City State Zip Code

3. Name Last First Telephone (H) (W)

Address Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care Telephone

Address Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian Date

**INSTRUCTIONS TO PARENT/GUARDIAN:**

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Condition(s): \_\_\_\_\_

\_\_\_\_\_

Medications currently being taken by your child: \_\_\_\_\_

\_\_\_\_\_

Date of your child's last tetanus shot: \_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_

\_\_\_\_\_

**EMERGENCY MEDICAL INSTRUCTIONS:**

(1) Signs/symptoms to look for: \_\_\_\_\_

\_\_\_\_\_

(2) If signs/symptoms appear, do this: \_\_\_\_\_

(3) To prevent incidents: \_\_\_\_\_

\_\_\_\_\_

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OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Note to Health Practitioner:**

If you have reviewed the above information, please complete the following:

\_\_\_\_\_  
Name of Health Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Health Practitioner

(\_\_\_\_\_)\_\_\_\_\_  
Telephone Number

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**Please note that any medication or medicated OTC creams need to be indicated on the Medication Administration Form signed by a physician (OCC-1215), which is part of the RFI for forms to attend school.**

Please indicate your preference on the following items:

We are required by Maryland State Law to offer milk for children at lunchtime. Please indicate whether or not your child may be offered milk. **YES** \_\_\_\_ **NO** \_\_\_\_

At times, parents would like non-medicating creams, sunscreen or insect repellent applied to their child during school hours.

Creams **YES** \_\_\_\_ **NO** \_\_\_\_ **TYPE** \_\_\_\_\_ Insect Repellent **YES** \_\_\_\_ **NO** \_\_\_\_ **TYPE** \_\_\_\_\_

Sunscreen **YES** \_\_\_\_ **NO** \_\_\_\_ **TYPE** \_\_\_\_\_ Comments or Instructions for above choices \_\_\_\_\_

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