

Emergency Information and Immunization Record Card

Child's Name: _____ Date Enrolled: _____ Updated: _____
Home Address: _____ Date Disenrolled: _____
Street City State Zip
Home Phone: _____ Date of Birth: _____ Sex: male female

Mother or Guardian Name: _____
Home Address: _____ Street City State Zip
Home Phone: _____ Cell Phone: _____
Business Name: _____ Work Phone: _____
Business Address: _____ Street City State Zip
Signature: _____

Father or Guardian Name: _____
Home Address: _____ Street City State Zip
Home Phone: _____ Cell Phone: _____
Business Name: _____ Work Phone: _____
Business Address: _____ Street City State Zip
Signature: _____

If Medical Care is Necessary, Call:

DOCTOR: _____
Name Address City State Zip Phone

HOSPITAL: _____
Name Address City State Zip Phone

Does your child have insurance coverage? No Yes Name of Insurance Company _____
(Optional)

In case of injury or sudden illness, _____ will be called first. I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

In case of an emergency, or if I cannot be contacted to pick up my child, I hereby authorize the following person(s) to pick up my child.

Name: _____ Name: _____

Address: _____ Address: _____
Street City State Zip Street City State Zip

Telephone: _____ Cell phone: _____ Telephone: _____ Cell phone: _____

Name: _____ Name: _____

Address: _____ Address: _____
Street City State Zip Street City State Zip

Telephone: _____ Cell phone: _____ Telephone: _____ Cell phone: _____

The following person(s) may **not** remove my child from the center:

Name: _____ Name: _____

Custody papers have been provided and are on file at the facility. yes no

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent or Guardian printed name Signature Date: _____

