EMERGENCY CONTACT INFORMATION

OLP ECC takes all measures necessary to ensure the safety of your child while in the care of our staff. To ensure the safety of your child, we ask you to complete the following information completely and accurately. Please provide the names, complete addresses, and all telephone numbers for those authorized to be contacted in case of any emergency.

Child's Name: _____ Birthdate: _____

Home Address: _____

Parent or Guardian: _____

Telephone Numbers:

Home _____ Work _____

Cell Phone/Pager _____ E-mail Address: _____

Home Address: _____

Place of Employment: _____
Regular work days _____ Regular work hours _____

Parent or Guardian: _____
Telephone Numbers:
Home _____ Work _____
Cell Phone/Pager _____ E-mail Address: _____
Home Address _____
Place of employment: _____
Regular work days _____ Regular work hours _____

Emergency Contacts are used when attempts to reach parents are not successful. Emergency contacts are local individuals with real ability to be reached and who are authorized to pick child up and seek proper medical attention for the child when necessary.

Name#1: _____ Relationship _____

Telephone Numbers: Home/Cell _____ Work _____

Name#2: _____ Relationship _____

Telephone Numbers: Home/Cell _____ Work _____

People Authorized to pick my child up. Pick up person must be 18 years of age. Proper identification will be required from all authorized contacts. Any updates to these contacts must be done in writing.

Name: _____ Best Contact Number: _____

Name: _____ Best Contact Number: _____

Name: _____ Best Contact Number: _____

Name: _____ Best Contact Number: _____

We must have written permission for anyone other than parent/guardian to pick child up from the center.

Child's Primary Source of Medical Care

Physician's Name:_____Phone #:_____

Address:_____

Hospital to take child in case of an emergency:_____

Dentist's Name (either Child's or Parent's):_____

Address:_____Phone#:_____

Child's Health Insurance

Name of Insurance Plan:_____

Certificate Number (or ID) #:_____ Group #: _____

Policy Holder's Name:_____

Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations:

_____

_____

Parent/Legal Guardian Consent and Agreement for Emergencies

As parent/legal guardian, I give consent to have my child receive first aid by facility staff, and, if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. In accordance with Missouri State Licensing guidelines, records must be on file indicating the child has completed age-appropriate immunizations or is in the process of completing immunizations before the child may attend the center. I agree to review and update this information whenever a change occurs and at least once a year.

Date:_____ Parent/Guardian #1 Signature_____

Date:_____ Parent/Guardian #2 Signature_____

Review Date_____ Parent/Guardian Signature_____

Review Date_____ Parent/Guardian Signature_____

Review Date_____ Parent/Guardian Signature_____