

Building Blocks Learning Center
Emergency Contact Form

Today's Date _____

Name of Child _____ DOB _____

Mother's Info:

Name _____

Address _____

Phone # (h) _____ (c) _____ (w) _____

Place of Work _____

Father's Info:

Name _____

Address _____

Phone# (h) _____ (c) _____ (w) _____

Place of Work _____

Name and Phone # of two emergency contacts (other than parents):

1. _____ Phone _____

2. _____ Phone _____

Child's Physician _____ Phone _____

Name of Health Insurance for child _____

(Medical care, if required, will be paid for by parents)

Does your child have any food/dietary allergies? Yes No

If yes, please list: _____

Does your child have any medical issues--special needs, medications, etc.? Yes No

If yes, please explain: _____

I give my consent for emergency medical care : _____

(parent signature)