

EMERGENCY INFORMATION

StudentName(s) _____ Program _____ D.O.B. _____
_____ Program _____ D.O.B. _____
_____ Program _____ D.O.B. _____

Home Address _____
_____ Home Phone _____

Father's Name _____ Work Phone _____ Cell phone _____
Mother's Name _____ Work Phone _____ Cell phone _____

Family Physician _____ Telephone _____
Medical Insurance Group _____ Policy # _____

Person to contact in an emergency if parent cannot be reached:
_____ Phone _____

Does your child have any allergies? _____
**Medications that parents will allow the daycare/school to give to the child:
_____ Non-Aspirin
_____ First-Aid(Cream, sprays, cleaners, etc.)

In case of illness or accident, I desire to be contacted. If I, or the emergency person cannot be reached, permission is granted to Twin City Christian School/Daycare officials to arrange care for my child according to the seriousness of the case. I would prefer my child be taken to:
Leominster Hospital _____ Other: _____
Burbank Hospital _____

Signature of Parent/Legal Guardian _____ Date: _____

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Alternate Pick-Up Person(s) (OPTIONAL)

Name: _____

Telephone Number: _____ Relationship _____

Address: _____

City: _____ State _____ Zip _____

Name: _____

Telephone Number: _____ Relationship _____

Address: _____

City: _____ State _____ Zip _____

Alternate Pick-Up Person(s) (OPTIONAL)

Name: _____

Telephone Number: _____ Relationship _____

Address: _____

City: _____ State _____ Zip _____

Name: _____

Telephone Number: _____ Relationship _____

Address: _____

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