Emergency Information and Immunization Record Card

Child's Name: _____ Date of Enrollment: _____ Updated: _____

Street Address: _____ Date Disenrollment: _____

City, State, & Zip Code: _____ Date of Birth: _____ Sex: Male Female

Mother or Guardian:

Name: _____

Home Address: _____

City, State & Zip _____

Hm Ph: _____ Cell Ph: _____

Business Name: _____

Business Address: _____

City, State & Zip: _____

Wk. Ph: _____

Signature: _____

Father or Guardian:

Name: _____

Home Address: _____

City, State & Zip _____

Hm Ph: _____ Cell Ph: _____

Business Name: _____

Business Address: _____

City, State & Zip: _____

Wk. Ph: _____

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: _____

Address: _____

City, State & Zip: _____

Ph: _____ Cell Ph: _____

Name: _____

Address: _____

City, State & Zip: _____

Ph: _____ Cell Ph: _____

Name: _____

Address: _____

City, State & Zip: _____

Ph: _____Cell Ph: _____

Name: _____

Address: _____

City, State & Zip _____

Ph: _____ Cell Ph: _____

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:

_____ **Date:** _____

Parent or Guardian printed name Signature