

## EMERGENCY INFORMATION

NOTE: THIS ENTIRE FORM MUST BE UPDATED SEMI-ANNUALLY.

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First

Enrollment Date \_\_\_\_\_ Hours & Days of Expected Attendance \_\_\_\_\_

Child's Home Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

Parent/Guardian 1:	Parent/Guardian 2:
Name:	Name:
Home Address:	Home Address:
Home Phone:	Home Phone:
Employer/School:	Employer/School:
Employer/School Address:	Employer/School Address:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email:	Email:
Personal Security Pin:	Personal Security Pin:

Name of Person Authorized to Pick-Up Child (*daily*) \_\_\_\_\_  
Last First Relationship to Child

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code Telephone

When parents cannot be reached, list at least two people who may be contacted to pick up in an emergency:

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Last First  
 Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Last First  
 Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

3. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Last First  
 Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_  
Street/Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_  
Street/Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Health Insurance Provider and Policy Number: \_\_\_\_\_

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, in the event such an emergency occurs and I cannot be reached, I hereby authorize Kiddie Academy® to provide for the transportation of my child to (Name of Hospital) \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

(or the nearest hospital) and to secure for my child all necessary medical treatment. I understand that the teachers in the child care center are trained in the basics of first aid and I authorize them to provide my child with first aid when appropriate.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**SEMI-ANNUAL UPDATE (Sign if information remains the same, otherwise complete a new form)**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date