Emergency Information

Child's Name:
Address:
City, ST Zip
Home Phone:

Date Enrolled:
Birthdate:

Parent 1 Name:
Work Phone#:
Work Place:
Occupation:
Cell Phone #:
Email:

Parent 2 Name:
Work Phone #:
Work Place:
Occupation:
Cell Phone#:
Email:

Doctor:
Phone #:
Address:
Last Physical:

Allergies:
Health Concerns:

Dentist:
Phone #:
Address:

Persons Authorized To Pick Up Your Child (Name, Phone Number& Address)

Name	Phone Number	Address	Emergency Contact? (Y/N)
1)			
2)			
3)			
4)			

I hereby give permission for my child to go on neighborhood walks with their teachers. Yes/No
I hereby give permission for my child to be photographed for a) classroom use Yes/No
b) promotional publications (website and brochures) Yes/No

I hereby give permission that my child may be given emergency treatment by a qualified staff member at University Temple Children's School. I also give my permission for my child to be transported by ambulance or aid car to an emergency care center for treatment. In the event that I cannot be contacted, I further consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by a physician to safeguard my child's health.

Signature _____ Date: _____