St. James Preschool

Grow, Explore, Discover, Imagine Together

581 Valley Road
Montclair, NJ 07043

Medical/Emergency Contact Form

Child's Name _____Date of Birth _____
(First) (M.I.) (Last)

Address

_____
(Street) (City) (State) (Zip)

Parents' Names:
CALL FIRST:
Parent #1: _____ Cell # (_____) _____

Parent #2:_____ Cell # (_____) _____

Home Tel. # (_____) _____

Does your child have any allergies or sensitivities? Y / N

Please list: _____

Epipen needed?_____ Benedril needed? _____

Physician's Name _____ Phone # (____)_____

Insurance Carrier _____ Policy # _____

People to call if a parent cannot be reached:

1. _____ Phone # (____)_____

2. _____ Phone # (____)_____

I (we) state that we are the parent(s)/guardian(s) having legal custody of the above child attest that the information above is correct. I (We) authorize the above child care center director or director's designee to obtain emergency treatment for my child. I consent to an x-ray examination, anesthetic, medical, or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

<u>The following steps will be followed in an emergency:</u>

1. The parent/guardian will be contacted immediately.

2. The child's physician will be contacted

3. There will be an attempt to contact you through any of the emergency persons listed above

4. If we cannot contact you or your child's physician, we will do any or all of the following

a. Call for emergency paramedics assistance/transportation

b. Call another physician

c. Have the child transported to an emergency hospital in the company of a staff member

5. The center will not be responsible for complications that may occur as a result of false information given at the time of enrollment.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian name printed:

_____