Christian Beginnings Preschool

of St. John Vianney

Emergency Information 2019-2020

Childs Name:_____ DOB_____ Female_____ Male_____

Address:_____Phone:_____

PARENT/GUARDIAN INFORMATION:

Mother's name: _____

Cell phone (mom) _____

Email: _____

Mother's employer _____

Mother's work phone _____

Father's name_____

Cell phone (dad) _____

Email: _____

Father's employer _____

Father's work phone _____

MEDICAL EMERGENCIES

Does your child have any allergies? ☐ Yes ☐ No If yes, please explain: _____

Does your child have a condition which might require emergency medical care? ☐ Yes ☐ No If yes, please explain:

Condition: _____

Signs/Symptoms:_____

If symptoms appear, take this action: _____

Other information: _____

Child's Doctor: Name _____ Phone: _____

Child's Dentist: Name_____ Phone: _____

TRANSPORTATION/EMERGENCY PICK UP

Who will be transporting the child to/from school? _____

Who else has permission to transport your child? (If the child lives with only one parent, you must include the non-custodial parent's name here in order for that parent to pick up the child). _____

_____

When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

Name_____ phone number(s)_____

Name_____ phone number(s)_____

Name_____ phone number(s)_____

Parent or Guardian Signature_____ Date_____