

Child Emergency Information

Items indicated with an * are required by Child Care Licensing Regulations 7 AAC 57 and/or Child Care Assistance Regulation 7 AAC 41

Child's Information

*Child's Name: _____

Date of Birth: _____

Siblings Enrolled? Yes No

Any Custody Arrangements / Restrictions Yes No

Sibling Name: _____

Parent(s) or Legal Guardians Information

*Name: _____ *Relationship: _____ *Cell Phone: _____ *Home Phone: _____

Physical Home Address: _____

Place of Employment: _____

*Employment or Other Main Phone: _____

Email: _____

Name: _____ Relationship: _____ Cell Phone: _____ Home Phone: _____

Physical Home Address: _____

Place of Employment: _____

Employment or Other Main Phone: _____

Email: _____

Persons Authorized to Pick-Up Child

List the names and phone numbers of person who can pick up your child. You must include at least one name and phone number of an individual who can assume responsibility for your child if you cannot be reached immediately in an emergency. Clarify whether these individuals can pick up the child in emergency situations only or at other routine times.

*Name: _____ *Daytime Phone: _____ Cell Phone: _____ Emergency Routine

Name: _____ Daytime Phone: _____ Cell Phone: _____ Emergency Routine

Name: _____ Daytime Phone: _____ Cell Phone: _____ Emergency Routine

Name: _____ Daytime Phone: _____ Cell Phone: _____ Emergency Routine

MEDICAL INFORMATION AND RELEASE FOR MEDICAL CARE

Items indicated with an * are required by Child Care Licensing regulations 7 AAC 57 and/or Child Care Assistance regulation 7 AAC 41.

Child's Name: _____

Child Care Facility: Fairbanks Montessori School

*Health Concerns

My child has no health concerns, including allergies or medications

-OR-

My child has the following: _____

Medication, medical, or other treatments: _____

Allergies (including foods, drugs, others): _____

Special Needs (ex: dietary, health related services): _____

PREFERRED PHYSICIAN AND MEDICAL FACILITY INFORMATION

*Physician's Name: _____ Physician's Phone: _____

*Preferred Hospital: _____

I verify the information contained on this record is correct and complete. I hereby give the permission for emergency medical treatment, including emergency transportation to a health care facility, for my child. I understand that every effort will be made to locate me or my child's other parent or legal guardian as soon as possible. I understand my obligation to keep my child care provider informed of my whereabouts. This authorization remains valid until revoked by myself.

*
Signature: _____ Date: _____

Information on this Child Emergency Record must be reviewed and updated at least semi-annually and when new information becomes available.

Date & Initial _____ Date & Initial _____ Date & Initial _____ Date & Initial _____ Date & Initial _____