SOUTHERN HILLS CHILD DEVELOPMENT CENTER EMERGENCY INFORMATION

Child Name: _____ DOB: _____

Address: _____

_____

Parent/Guardian 1: _____

Cell: _____ Home: _____ Work: _____

Email: _____

Parent/Guardian 2: _____

Cell: _____ Home: _____ Work: _____

Email: _____

Individuals other than parent/guardian authorized to pick up your child:

Name: _____ Relation to Child: _____

Phone: _____

Name: _____ Relation to Child: _____

Phone: _____

Name: _____ Relation to Child: _____

Phone: _____

HEALTH CONCERNS

Food Allergies: _____

Environmental Allergies: _____

Medications Taken: _____

History of Seizures: Yes: _____ No: _____

OTHER INFORMATION

Has your child been left in a group setting before: Yes: _____ No: _____

If in a napping room: Does your child have a special blanket/paci/etc…they sleep with: Yes No

If yes, what do they call it: _____

Any other information that would assist us in working with your child? _____

_____

_____

Parent/Guardian Signature: _____ Date: _____