

Child's Name: _____
Child's Classroom: _____

Emergency Contact Form

OLP ECC takes all measures necessary to ensure the safety of your child while in the care of the staff. To ensure the safety of your child, **we ask that you complete the following information completely and accurately.**

In the event of a medical emergency, the staff will obtain emergency medical treatment at the nearest emergency room. To further ensure the safety of your child, we require that you accurately include the **names, complete addresses, and all telephone numbers of those authorized to be contacted for your child in case of an emergency. This form must be updated when any changes in information occur.**

Primary Home address _____ City _____ State ____ Zip Code _____
Home Phone _____

Second Address and name (if parent/guardian resides in separate households):

Second Home Phone (if applicable): _____

Primary Parent/Guardian's Name _____ Work Phone _____

Name of Business _____

Work Address _____

Work Hours _____

E-mail Address _____ Cell Phone _____

Parent/Guardian's Name _____ Work Phone _____

Name of Business _____

Work Address _____

Work Hours _____

E-mail Address _____ Cell Phone _____

Whom should we contact in case of an emergency if parents/guardians cannot be reached?

Emergency contacts are someone other than parents/guardians. Only provide names, addresses, and phone numbers of local individuals with real ability to be reached and who are authorized to pick up the child and seek proper medical attention for the child, when necessary. You must provide at least one emergency contact person other than parent or guardian, complete with name, address, and phone numbers.

1. Name _____ Relationship _____

Home Address _____ Phone _____

Name of Business _____ Work Cell Home

2. Name _____ Relationship _____

Home Address _____ Phone _____

Name of Business _____ Work Cell Home

3. Name _____ Relationship _____

Home Address _____ Phone _____

Name of Business _____ Work Cell Home

The following individuals, who may not be emergency contacts, have authorization to pick up your child on occasion. Families understand that they must update any additions or deletions in writing. Furthermore, families understand that these people must be at least 18 years of age and proper identification will be required.

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Medical History

Physician's Name _____ Phone (____) _____
Address _____
Child's Name _____ DOB _____ Age _____

In accordance with Missouri State Licensing guidelines: "records must be on file indicating that the child has completed age-appropriate immunizations or is in the process of completing immunizations before the child may attend the center. This form gives OLP ECC permission to seek medical attention if the parent/guardian cannot be reached.

Parent/Guardian Signature _____ Date _____

In case of an emergency, please list any medications in which your child is allergic.

Please give a brief summary of your child's medical history. For example surgeries, asthma, food allergies etc. (necessary for medical attention)

