

EMERGENCY CARE INFORMATION:

Child's Full Name _____

Name of Child's Doctor _____ Office Phone _____
Address _____

Name of Child's Dentist _____ Office Phone _____
Address _____

Hospital Preference _____

If you cannot be contacted or cannot pick up your child, please give the name of three people whom your child can be released to:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

If you desire to change any of this information later, you may do so by calling the Little Lambs Learning Center office and giving a password that you choose and would be easy for you to remember. List a hint that we can give you if you forget. Do not share this password with anyone.

List your password: _____

Password hint: _____

I agree that the director or alternate may authorize the physician of his/her choice to provide emergency care in the event that neither the family physician nor I can be contacted immediately.

(Signature of Parent)