



EMERGENCY CONTACT INFORMATION

CHILD'S INFORMATION:

Name: _____ DOB: _____ SSN: _____

Primary Address: _____

Primary Care Physician: _____ Phone: _____

PCP Address: _____

Insurance Name: _____ ID No.: _____

Dentist Name: _____ Phone: _____

Dental Insurance Carrier: _____ ID No.: _____

Maple Leaf Childcare Center is authorized to obtain emergency transportation to and/or emergency medical care for the above listed child at the nearest hospital's emergency room, or at the emergency room the EMS/Ambulance Service is required to transport patients to at the time of emergency.

Parent's Printed Name

Date

Parent's Signature

Please attach a separate sheet of paper for additional Medical Professional information as necessary due to your child's unique medical needs.

MOTHER/GUARDIAN'S INFORMATION:

Name: _____ Email: _____

Home Address: _____

Employer Name: _____ Phone: _____

Employer Address: _____

Work Schedule: Days & Hrs: _____

Home Phone: _____ Cell Phone: _____

FATHER/GUARDIAN'S INFORMATION:

Name: _____ Email: _____

Home Address: _____

Employer Name: _____ Phone: _____

Employer Address: _____

Work Schedule: Days & Hrs: _____

Home Phone: _____ Cell Phone: _____