NH SCHOOL OF APPLIED LEARNING

Igniting Ingenuity

EMERGENCY CONTACT INFORMATION

TO THE PARENT OR GUARDIAN: This form must be completed for each of your children who will be enrolled in the program, and must be updated whenever information changes. You must also either complete a new form annually, or update this form annually by following the instructions at the bottom of the reverse side of this form.

DATE OF CHILD'S ENROLLMENT _____

Child's Name:	Date of birth:
Address:	Phone number:

IDENTIFYING INFORMATION OF PARENT/S OR GUARDIAN/S LEGALLY RESPONSIBLE FOR CHILD:

Name:	Name:
Address:	Address:
Home phone number:	Home phone number

Indicate where parent/guardian above can be reached while child is in care. Include name, address and phone number of business if applicable. Include any special instructions, e.g. pager, cell phone, etc.

Business name:	Business name:
Address:	Address:
Phone number: Hours:	Phone number: Hours:
Special instructions for reaching parent/guardian:	

EMERGENCY CONTACT PERSON: You (parent/guardian) are required to list at least 1 person with whom you would feel comfortable leaving your child, and who could assume responsibility for your child if you could not be reached immediately in an emergency, or if for some reason you could not pick up your child and were unable to communicate with the program. Examples: if your child were sick and you were not accessible, or if you experienced sudden illness between work and picking up your child.

Name:	Name:
Relationship:	Relationship:
Address:	Address:
Phone number:	Phone number:

NON-EMERGENCY ALTERNATE PICK-UP PERSON/S: I, _____

(Parent/Guardian Signature) Date Signed

Authorize the following individual(s) to pick up my child from the program on a non-emergency basis.

Name:	Name:
Relationship:	Relationship:
Address:	Address:
Phone number:	Phone number:

EMERGENCY CONTACT INFORMATION

NON-EMERGENCY ALTERNATE PICK-UP PERSON/S continued

Name:	Name:
Relationship:	Relationship:
Address:	Address:
Phone number:	Phone number:

MEDICAL INFORMATION

Any chronic conditions, allergies or medications that could be important in case of sudden illness or injury:
Child's usual physician: Phone number:
Physician's address:

EMERGENCY MEDIAL TREATMENT AUTHORIZATION

I hereby give permission for the staff of SOUTHERN NH MONTESSORI ACADEMY to provide simple first aid treatment to my child, _____ when necessary. In the event of a more serious illness or injury, I give permission for my child to be transported to a hospital or other emergency medical facility to receive emergency medical treatment. I also authorize ambulance/rescue squad attendants to administer such treatment as is medically necessary, and I authorize licensed health practitioners working in the hospital or emergency medical facility to examine and provide emergency medical treatment to my child if warranted. I understand that I will be contacted by child care program personnel as soon as possible regarding any emergency involving my child.

_____

Parent/Guardian Signature **Date**

ANNUAL UPDATE:

PARENT/GUARDIAN MUST REVIEW THIS INFORMATION ANNUALLY, MAKE NECESSARY CHANGES AND INITIAL & DATE BELOW TO VERIFY THAT THE INFORMATION IS CURRENT.

Parent/Guardian Initials:	Date:	Parent/Guardian Initials:	Date:
Parent/Guardian Initials:	Date:	Parent/Guardian Initials:	Date: