EMERGENCY CARD FOR *Woods Hollow Children's Center*

All information must be complete.

CHILD'S NAME:_____ BIRTH DATE:_____
Last First Middle

HOME ADDRESS:_____ Room:_____
Street City Zip *First Date of Attendance:*_____

PLEASE INDICATE WITH AN * WHICH PARENT TO CONTACT FIRST IN CASE OF EMERGENCY /ILL CHILD etc

PARENT/GUARDIAN NAME:	PARENT/GUARDIAN NAME:
HOME ADDRESS: (include street name, city, zip)	HOME ADDRESS: (include street name, city, zip)
HOME PHONE: ☎	HOME PHONE:☎
WORK PHONE:☎	WORK PHONE:☎
CELL/PAGER NUMBER:☎	CELL/PAGER NUMBER:☎
EMPLOYER NAME **&** ADDRESS: (must include street name, city, zip)	EMPLOYER NAME **&** ADDRESS: (must include street name, city, zip)
All parents/guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach copy, if any.	All parents/guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach copy, if any.

EMERGENCY CONTACTS: Persons listed are authorized to pick up my child and are contacted when either parent/guardian cannot be reached.
ALL MUST BE WITHIN 1 HOUR DRIVE OF THE CENTER and at least 18 years of age..
These people are also authorized to have access to health information about my child in case of an emergency.

1. _____
Name *Home Address* *Relationship to Child* *Day Phone #☎*

2. _____
Name *Home Address* *Relationship to Child* *Day Phone #☎*

PERSONS AUTHORIZED TO PICK UP MY CHILD other than parent/guardian and emergency contacts(must be at least 18 years of age)
Proper identification is required before child will be released

NAME	RELATIONSHIP TO CHILD	HOME ADDRESS *(STREET, CITY, ZIP)*	PHONE # WHERE CAN BE REACHED WHILE CHILD IS AT CENTER
1.			☎
2.			☎
3.			☎
4.			☎
5.			☎

CHILD'S PHYSICIAN:_____
NAME CLINIC ADDRESS PHONE NUMBER☎

ALLERGIES OR OTHER HEALTH CONCERNS:_____
(info must also be on Health History Form and Child Health Report)

INSURED'S NAME/POLICY HOLDER:_____ INSURANCE COMPANY:_____

I hereby give my consent for emergency medical treatment to be administered if I cannot be reached immediately.
I understand the policies and procedures set forth by WHCC for first aid practices and procedures for serious accidents as noted in the Parent Handbook.
It is the parent's responsibility to make sure all information is up-to-date in case a parent needs to be contacted on any given day.

SIGNATURE OF PARENT:_____DATE:_____
**A typed copy will be provided for you to verify all info and sign after information is received.