EMERGENCY RECORD CARD

CHILD'S INFORMATION

Last Name:	Date of Birth:
First Name:	First Day in Care:
Siblings Enrolled ☐ Yes ☐ No	Any Custody Arrangements? ☐ Yes ☐ No ☐ NA

NAMES OF PARENT(S) OR LEGAL GUARDIAN(S) CONTACT INFORMATION

Name:	**Relationship:**	**Name:**	**Relationship:**
Place of Employment / Other:		Place of Employment / Other:	
Phone:		Phone:	
Physical Home Address:		Physical Home Address:	
Cell Phone: ☐ ok to send text msg.	Home Phone:	Cell Phone: ☐ ok to send text msg.	Home Phone:
E-mail Address:		E-mail Address:	

PERSONS AUTHORIZED TO PICK-UP CHILD – Emergency / Routine

List the names and phone numbers of persons who can pick up your child. You must include at least one name and phone number of an individual who can assume responsibility for your child if you cannot be reached immediately in an emergency. Clarify whether these individuals can pick up the child in emergency situations only or at other routine times. Individuals cannot be under the age of 16.

Name:	Daytime Phone:	Cell:	☐ Emergency ☐ Routine
Name:	Daytime Phone:	Cell:	☐ Emergency ☐ Routine
Name:	Daytime Phone:	Cell:	☐ Emergency ☐ Routine
Name:	Daytime Phone:	Cell:	☐ Emergency ☐ Routine

****Signature of Parent or Legal Guardian and periodic updates required on reverse side of this form****

MEDICAL INFORMATION and RELEASE FOR MEDICAL CARE

Child's Name:	**Child Care Facility:** **Anchorage Montessori School**

☐ **My child has NO ongoing health concerns**, including allergies or ongoing medications

- OR -

☐ **My child has the following chronic health concerns:**

☐ Allergies (list all):

☐ Asthma ☐ Diabetes ☐ Seizures or epilepsy ☐ Other (list):

☐ My child takes the following ongoing medications:

PREFERRED MEDICAL FACILITY INFORMATION

Physician's Name:	Physician's Phone (recommended):

Preferred Hospital: ☐ Providence ☐ Regional ☐ ANMC ☐ JBER ☐ Other:

I, the parent or legal guardian of _____, am verifying that this medical information is correct and complete. I hereby give the above named facility permission to seek emergency medical treatment, including necessary emergency paramedic transport for my child. I understand that every effort will be made to locate me or my child's other parent or legal guardian as soon as possible. I understand my obligation to keep my child care provider informed of my whereabouts. I will assume the cost of necessary medical or surgical care and any related medical transportation costs.

_____ _____

Signature of Parent or Legal Guardian **Date Signed**

Information on this Emergency Record Card must be Reviewed and Updated Semi-annually

Date & Initial		**Date & Initial**		**Date & Initial**		**Date & Initial**		**Date & Initial**	