The Child Development Program at Taft

EMERGENCY INFORMATION

CHILD'S NAME: _____DOB____/____/____
ADDRESS:_____TOWN_____Zip:_____
HOME PHONE:_____CELL PHONE(M)_____
(D) _____

FATHER'S NAME:_____OCCUPATION_____
MOTHER'S NAME:_____OCCUPATION_____
Legal Guardian (if applicable)_____

FATHER'S EMPLOYER:_____
ADDRESS:_____TOWN:_____
PHONE NUMBER:_____EXT._____

MOTHER'S EMPLOYER:_____
ADDRESS:_____TOWN:_____
PHONE NUMBER:_____EXT._____

ALLERGIES(be very specific):
_____

IF UNABLE TO CONTACT PARENTS, OR IN CASE OF EMERGENCY, THE FOLLOWING PEOPLE MAY ACCEPT RESPONSIBILITY FOR _____:

Your child will be released only to the individuals listed below:

1. Name_____
   Phone:_____
   Relationship_____
   Address_____

2.Name_____
Phone _____
Relationship_____
Address_____

Child's Doctor_____
Doctor's Phone Number_____
Doctor's Address_____
Hospital Preference_____

PARENT SIGNATURE_____Date:___/___/____
DIRECTOR SIGNATURE_____Date:___/___/____