L'Ecole
Childcare Centres

EMERGENCY INFORMATION RECORD

"In the event that I cannot be reached, I hereby give my permission for my child to receive any necessary emergency medical care or treatment. I understand that every effort will be made to contact me or my spouse before such action is taken. I will be responsible for the payment for such treatment."

Child's Name:_____ Date of Birth:_____

Address:_____

Name of Mother:_____

Business Address:_____

Home Phone:_____

Work Phone:_____

Name of Father:_____

Business Address:_____

Home Phone:_____

Work Phone:_____

Person(s) to contact if parents are unavailable:

Name:_____ Relationship to child:_____

Address:_____

Phone:_____ Mobile:_____

Child's Physician:_____ Phone:_____

Hospital Preference:_____

_____
Signature of Parent/Guardian

Date:_____