

Emergency Contact Form

To Be Completed By Parent(s)		
Date form completed	Revised	Initials
Child's Name:	Birth Date:	Nickname:
Home Address:		
Parent/Guardian Name:		
Home Phone Number:	Work/Cell Phone Number:	
Emergency Contact Names & Relationship:		
Home Phone Number:	Work/Cell Phone Number:	
Primary Language:	Phone Number(s):	
Physicians:		
Primary Care Physician:	Emergency Phone:	
	Fax:	
Current Specialty Physician:	Emergency Phone:	
Specialty:	Fax:	
Current Specialty Physician:	Emergency Phone:	
Specialty:	Fax:	
Does the Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of the Child's Insurance Carrier:	
I give my consent for my child's Health Care Provider and Child Care Provider to discuss information on this form.		
Signature:		Date: