

This form is editable. Please complete it digitally and return it to the Stoler Early Learning Center prior to your child's first day of school. Typing this form will allow us to clearly and easily read your responses in the event of an emergency. Thank you in advance for thoroughly completing this.



CAFCP Enrollment: Yes: ___ No: ___

Meals your child will receive while in care:

BK ___ LN ___ SU ___ AM Snk ___ PM Snk ___ Evng Snk ___

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

- (1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.
- (3) Breakfast may be sent in from home if your child arrives prior to 8:30 am. Lunch must be sent in from home or ordered through our in house cafe. The ELC will provide children 2 years old and up with morning and afternoon snack daily.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____

Street/Apt. # _____ City _____ State _____ Zip Code _____

Parent/Guardian Name(s)	Relationship	Contact Information		
		Email:	C:	W:
			H:	Employer:
			H:	Employer:

Please list all names that are authorized to pick your child up daily (including parents and those listed as emergency contacts below). These people must also be set up on our Family Portal to sign your child in and out.

Name of Person Authorized to Pick up Child (daily) _____
 Last _____ First _____ Relationship to Child _____

Address _____
 Street/Apt. # _____ City _____ State _____ Zip Code _____

Any Changes/Additional Information _____

ANNUAL UPDATES

(Initials/Date) _____ (Initials/Date) _____ (Initials/Date) _____ (Initials/Date) _____

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
 Last _____ First _____

Address _____
 Street/Apt. # _____ City _____ State _____ Zip Code _____

2. Name _____ Telephone (H) _____ (W) _____
 Last _____ First _____

Address _____
 Street/Apt. # _____ City _____ State _____ Zip Code _____

3. Name _____ Telephone (H) _____ (W) _____
 Last _____ First _____

Address _____
 Street/Apt. # _____ City _____ State _____ Zip Code _____

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
 Street/Apt. # _____ City _____ State _____ Zip Code _____

IN EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM.

Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

Note to Health Practitioner: Child's pediatrician's name and contact number is required.

If you have reviewed the above information, please complete the following:

Name of Health Practitioner

Date

Signature of Health Practitioner

Telephone Number