



Emergency Information Form

Child's Name:

Gender:

DOB:

Mother's/Guardian's Name:

Home address:

Zip Code:

Home Phone:

Work Phone:

Cell:

Email:

Place of Occupation:

Father's/Guardian's Name:

Home address:

Zip Code:

Home Phone:

Work Phone:

Cell:

Email:

Place of Occupation:

Emergency Contacts

Please list two people who may be contacted in an emergency.

1. **Name:**

Relationship:

Telephone:

2. **Name:**

Relationship:

Telephone:

Child's Healthcare Provider

Name:

Telephone:

Allergies, Medications and Special Health Conditions

List any applicable here:

Permission to Seek Medical Emergency Care

In emergencies requiring immediate medical care, your child will be taken to the nearest hospital emergency room. By submitting this form you authorize TPCDC to have your child transported to the hospital to receive emergency care.

Authorized by: