Early Beginnings
Child Development Center

v1/2022

Student Emergency Medical/Contact Form

at Jackson Day School

Child's Name: _____Age:_____ Grade _____Birthdate:_____

Address_____
Street City State Zip

Father/Guardian's Name:_____ Work Phone:_____ Cell:_____

Mother/Guardian's Name:_____ Work Phone:_____ Cell:_____

Please list any **disabilities**, diagnoses or special needs: (provide IEP/504 accommodations if necessary):_____
_____

Please list any **medications** they are on: _____
*You must also complete a Medicine Authorization Form if medications are kept on campus

Please list any **allergies** (Insect bites, food allergies, Medicine, etc….) _____
_____

**I authorize Early Beginnings to transport my child for programming events I am notified of:* *(Initial)* _____

Authorization for Emergency Medical Attention for (Child's Name) _____

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to call, release, and instruct emergency services personnel for my child and/or take my child to:
Name of Family Doctor Address Phone #
Or to (Name of hospital or clinic) Address Phone # Insurance Policy Holder: Insurance company:
Insurance Group #:_____Subscriber #:_____ Insurance company Phone: _____ I give consent for necessary emergency treatment when my child is in the care of this physician and/or hospital/clinic/ or emergency services personnel. _____ _____ _____ Parent/Guardian Name Parent/Guardian Signature Date

Alternate Pick-up Approval

I give consent for my child to be released to the following individuals for **pick-up** in the event I am unable to pick up my child or to contact these individuals if I cannot be reached in an **emergency**:

	Name	**Relationship**	**Phone**
1.			
2.			
3.			

_____ _____ _____
Parent/Guardian Name Parent/Guardian Signature Date