THE CHILDREN'S LEAGUE
League for the Handicapped, Inc.

EMERGENCY INFORMATION

Date Completed ____________________

It is necessary that you complete this form and return it to the Preschool. It is essential that we maintain current information. Please fill out **BOTH** sides of this form.

Child's Name ______________________________ Date of Birth ____________________

Child's Address ______________________________ Town/Zip ____________________ County________

Home Phone #________________ Child's Soc Sec #________________ Child's Weight ________ Male __ Female ___

Mother/Guardian ______________________________ Cell Phone #____________________

Mother's Address, if different ____

Place of Employment ______________________________ Phone # ____________________

Father/Guardian ______________________________ Cell Phone #____________________

Father's Address, if different ____

Place of Employment ______________________________ Phone # ____________________

Main Contact Email Address ____

Ins Co and #______________________________ Medicaid # ________________ Child receiving SSI? _____

EMERGENCY MEDICAL INFORMATION

Child's Physician ______________________________ Phone #____________________

Medications that child receives regularly ____

____

Does your child have an allergy to any foods, medications, insects, latex, or other substance? If yes, please list in detail, including treatment:

Allergy ______________________ Treatment ______________________________

Allergy ______________________ Treatment ______________________________

Has your child ever had a severe reaction to medicine, foods, insects which have required emergency care? ___________

If so, what was done? ____

Please check all that apply to your child:

- ☐ Can Talk
- ☐ Cannot Talk
- ☐ Can Walk
- ☐ Cannot Walk
- ☐ Speech Delay
- ☐ Vision Problems
- ☐ Other ______________
- ☐ Hearing Problem
- ☐ Tubes in Ear (L) or (R)
- ☐ Allergies- Seasonal
- ☐ Asthma
- ☐ Epilepsy/Seizure Disorder
- ☐ Feeding Tube
- ☐ Autism/PDD
- ☐ GERD/Reflux
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Diabetes Insipidus
- ☐ Hemophiliac

If you have any other information that you would like to share, please write below (special diet, health concerns, etc):

____

PLEASE COMPLETE OTHER SIDE

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Child's Name ______________________________ Date of Birth ____________

Emergency contacts (when parents cannot be reached) of those who may pick up your child at school or meet the bus (two required, NOT including parents):

1. Name ______________________ Relationship __________ Phone # __________
   Address ______________________ Town __________ Cell Phone # __________
2. Name ______________________ Relationship __________ Phone # __________
   Address ______________________ Town __________ Cell Phone # __________
3. Name ______________________ Relationship __________ Phone # __________
   Address ______________________ Town __________ Cell Phone # __________
4. Name ______________________ Relationship __________ Phone # __________
   Address ______________________ Town __________ Cell Phone # __________
5. Name ______________________ Relationship __________ Phone # __________
   Address ______________________ Town __________ Cell Phone # __________
6. Name ______________________ Relationship __________ Phone # __________
   Address ______________________ Town __________ Cell Phone # __________

Please notify The Children's League Main Office at 592-9331 of any changes to information provided. The emergency contact information pertains to the current school year only and will be provided to your child's transportation company as necessary.

____
Parent Printed Name

____
Parent Signature