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|   | **CHILD EMERGENCY CONTACT FORM** | **Date:** |   |
|   | **January 01, 2026** |   |
|   |   |   |   |   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   | **Parent / Legal Guardian Information** |   |   |
|   |   | **NAME** |   |   |   |   |   |   |   |   |   |   |
|   |   |  |   |   |  | **Name:** |  |   |   |   |
|   |   |   |   |  |  |   |   |   |   |   |   |   |
|   |   | **DATE OF BIRTH** |   |  |  | **Phone:** |  |   |   |   |
|   |   |  |   |  |  |   |   |   |   |   |   |   |
|   |   |   |   |  |  | **• • • • • • • • • • • • • • • • • • • • • •** | **MOTHER** |   |   |
|   |   | **AGE** |   |  |   |   |   |   |   |   |   |   |
|   |   |  |   |   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   | **Emergency Contacts** |   |   |
|   |   | **NICKNAME** |   |   |   |   |   |   |   |   |   |   |
|   |   |  |   |   |  | **Name:** |  |   |   |   |
|   |   |   |   |   |  |   |   |   |   |   |   |   |
|   |   | **HEIGHT** |   |   |  | **Phone:** |  |   |   |   |
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|   |   |   |   |   |  | **• • • • • • • • • • • • • • • • • • • • • •** | **NEIGHBOR** |   |   |
|   |   | **WEIGHT** |   |   |   |   |   |   |   |   |   |   |
|   |   |  |   |   |   | **Name:** |  |   |   |   |
|   |   |   |   |   |  |   |   |   |   |   |   |   |
|   |   | **HOME ADDRESS** |   |   |  | **Phone:** |  |   |   |   |
|   |   |  |   |   |  |   |   |   |   |   |   |   |
|   |   |  |   |   |  | **• • • • • • • • • • • • • • • • • • • • • •** | **AUNT** |   |   |
|   |   |   |   |   |  |   |   |   |   |   |   |   |
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|   | **Authorized Pickup Information** |   |
|   |  |  |  |  |  |  |  |  |  |  |  |   |
|   |  |  |  |  |  |  |  |  |  |  |  |   |
|   |   | **Name:** | **Relationship:** |  | **Phone:** |   |
|   |   |  |  |   |  |   |
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|   | **Medical Information** |   |
|   |  |  |  |  |  |  |  |  |  |  |  |   |
|   |  |  |  |  |  |  |  |  |  |  |  |   |
|   |   | **Allergies:** | **Medical Conditions:** |   |
|   |   | None |  |   |
|   |   |   |   |   |   |   |   |   |   |   |   |   |
|   |   | **Physician Name:**  | **Institution:** |  | **Physician Name** |   |
|   |   |  |  |   |  |   |
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|   | **Note in Case of Emergency** |  | **Form Valid Until** |   |
|   |  |   |
|   |  |  |  |  |  |  |  |  |  | **January 01, 2027** |   |
|   |   | In the event of an emergency, please follow the instructions provided by medical professionals and promptly contact the authorized emergency contacts listed above. |   |  |   |
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