



## EMERGENCY CONTACT FORM

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent(s)/Guardian(s): \_\_\_\_\_

### Allergies, Medical Conditions, or Concerns?

**No** my child does not have any allergies or medical conditions

**Yes** my child has the following allergies or medical conditions: \_\_\_\_\_

\_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_ Regular medications: \_\_\_\_\_

Physician Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Dentist Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Insurance company: \_\_\_\_\_ Policy number: \_\_\_\_\_

**PRIMARY CONTACT PERSON** - parent/guardian who will be nearby or most reachable in an emergency

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

Work phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

Home address: \_\_\_\_\_  
street city state zip

**SECONDARY CONTACT PERSON** - other parent/guardian or person we should call next in an emergency

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

Work phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

Home address: \_\_\_\_\_  
street city state zip

**OTHER PERSONS AUTHORIZED TO PICK UP YOUR CHILD FROM EELP**

Please list at least two. We recommend that the first contact person be nearby to EELP, for emergency pick-up.

1. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email (optional): \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email (optional): \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email (optional): \_\_\_\_\_

4. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email (optional): \_\_\_\_\_

5. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email (optional): \_\_\_\_\_

6. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email (optional): \_\_\_\_\_

7. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: \_\_\_\_\_ Email (optional): \_\_\_\_\_

**OUT-OF-STATE CONTACT** - required, in case of local emergency or interruption to communications

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Cell phone: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Other important info: \_\_\_\_\_

**CONSENT TO MEDICAL CARE & TREATMENT** - please complete, then sign and date, below

I understand that my child, \_\_\_\_\_, will not be released to persons other than parents and those "authorized" persons listed above. I agree to inform EELP immediately, in writing, of any changes to the information listed here. In the case of a disaster (earthquake, severe weather, etc.) that prevents me from reaching EELP, I authorize EELP staff to release my child to a known adult (a teacher, or the parent of another child) until I'm able to come meet them. I hereby give permission that my child may be given emergency treatment, to include First Aid and CPR by a qualified EELP staff member. I further authorize and consent to medical, surgical, and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right to informed consent of such treatment. I also give permission for my child to be transported by staff member, ambulance, or aid car to an emergency center for treatment. I hereby certify under penalty of perjury under the laws of the State of Washington that the information on this form is true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_