Wee Achievers Preschool - Emergency Card

Child's Full Name: _____ Sex: M ___ F ___
(Last) (First) (Middle Initial)
Preferred Name: _____ Birthdate: ____/____/____

Address: _____ Zip code: _____

Child resides with: _____

Father/Guardian's Information	Mother/Guardian's Information
Name: _____ **Address:** _____ **Phone:** _____ **Email:** _____ **Employer:** _____ **Address:** _____ **Phone:** _____	**Name:** _____ **Address:** _____ **Phone:** _____ **Email:** _____ **Employer:** _____ **Address:** _____ **Phone:** _____

*Listed below are the person(s) who shall **assume responsibility** for the child if parent/guardians cannot be reached immediately in an emergency*

1st Priority Emergency Contact	2nd Priority Emergency Contact
Name: _____ Address: _____ Phone #: _____ Relationship to child: _____	Name: _____ Address: _____ Phone #: _____ Relationship to child: _____

*Listed below are the person(s) **authorized to pick-up/drop off** the child*

Name: _____ Address: _____ Phone #: _____ Relationship to child: _____	Name: _____ Address: _____ Phone #: _____ Relationship to child: _____
Name: _____ Address: _____ Phone #: _____ Relationship to child: _____	Name: _____ Address: _____ Phone #: _____ Relationship to child: _____

*If my child needs to be taken to an emergency facility, he/she will be taken to the nearest one (Castle Medical Center). I give my consent for school authorities to take appropriate action for the safety and welfare of my child.

Parent/Guardian Signature: _____ Date: _____

Additional Health Information

My child has current Health Insurance and will remain insured while enrolled at Wee Achievers Preschool.

Health Insurance Carrier _____ Policy Number: _____

Physician's Name: _____ Phone Number: _____

Physician's Address: _____

_____ initial — I give permission to contact physician if I cannot be reached in the case of a health emergency

Please list any medical conditions your child receives regular care for (i.e asthma):
_____
_____
_____
_____

Allergies: _____
Date & type of last reaction: _____
Special measures that must be taken in the event your child has an allergic reaction: _____
_____

List of Medications taken: _____
_____

Other Health Concerns, disabilities, and/or special needs: _____
_____

Special Care Plan for Allergies

Description of Allergy: _____
Describe what signs/symptoms look like: _____
_____
Describe known triggers: _____
_____
Describe treatment: _____
_____
Possible side effects: _____
Program modifications required: _____
When to call parent/health provider regarding symptoms or failure to respond to treatment: _____
When to consider what condition requires urgent care or reassessment: _____
_____