**EMERGENCY FORM**

**PROGRAM LOCATION:**  **BOSCO 𑂽 ANGE 𑂽 ST. FRANCIS 𑂽 JL JORDAN 𑂽**

|  |  |  |  |
| --- | --- | --- | --- |
| CHILD’S NAME | D.O.B **M/D/Y** | ADDRESS | |
|  |  | STREET NAME & NUMBER: |  |
|  |  | CITY/TOWN: |  |
|  |  | POSTAL CODE: |  |

|  |  |
| --- | --- |
| **PARENT/GUARDIAN INFORMATION (First contact)** | **PARENT/GUARDIAN INFORMATION (Second contact)** |
| **NAME:** | **NAME:** |
| **PHONE:** | **PHONE:** |
| **ADDRESS:** | **ADDRESS:** |
| **EMAIL:** | **EMAIL:** |

|  |  |
| --- | --- |
| **EMERGENCY CONTACT INFO**  **(Other than listed above)** | **EMERGENCY CONTACT INFO**  **(Other than listed above)** |
| **NAME:** | **NAME:** |
| **PHONE:** | **PHONE:** |
| **ADDRESS:** | **ADDRESS:** |

**PICK-UP AUTHORIZATION**

The following individuals are authorized to pick up my child(ren) (Photo ID will be required to confirm identity before child will be released):

|  |  |
| --- | --- |
| **NAME:** | **NAME:** |
| **PHONE:** | **PHONE:** |
| **RELATIONSHIP TO CHILD:** | **RELATIONSHIP TO CHILD:** |

**ALLERGY INFORMATION**

Does your child have a life-threatening allergy (e.g., anaphylactic to peanuts or bee stings)?

YES NO

If yes, an individualized plan for an anaphylactic allergy that includes emergency procedures must be developed between the parent and the child care centre prior to the child’s start date.

Does your child have any allergies that are not life-threatening (food or other substance [e.g., latex])?

YES NO

|  |
| --- |
| If yes, please provide relevant details, including what your child is allergic to, symptoms of a reaction and treatment required: |
|  |

**Additional Emergency Information**

|  |
| --- |
| Please provide any special medical or additional information about your child that could be helpful in an emergency (e.g., medical conditions, skin conditions, vision/hearing difficulties): |
|  |

**PLEASE SELECT YOUR CHILD’S CARE REQUIRED (PLEASE MARK ALL THAT APPLY)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FULL TIME**  **(5 DAYS/WEEK)** | **PART TIME**  **(<5 DAYS/WEEK)** | **SCHEDULED**  **(ROTATING DAYS/WEEK)** | **BEFORE**  **SCHOOL**  **CARE** | **AFTER**  **SCHOOL CARE** |
|  |  |  |  |  |
| FOR PART TIME INDICATE DAYS REQUIRED: MON **𑂽** TUES **𑂽** WED **𑂽** THURS **𑂽** FRI **𑂽** | | | | |

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| **PLEASE PROVIDE ANY ADDITIONAL INFORMATION BELOW: (CUSTODY ARRANGEMENTS, SLEEP ROUTINES, FOOD PREFERENCES, SPECIAL REQUIREMENTS/ACCOMMODATIONS, PREFERRED CONTACT ETC)** |
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|  |  |
| --- | --- |
| PLEASE MARK ‘X’ IN BOX IF **PICTURES ARE ALLOWED** TO BE POSTED ON OUR FACEBOOK PAGE OR OUR WEBSITE (NO NAMES WILL BE ASSOCIATED WITH PICTURES) |  |