Building Blocks Learning Center

Emergency Contact/ Initial Information Form

Please do not leave any sections blank.

Name of Child _____ DOB _____

Parent #1 Info:

Name _____

Address_____

Phone # (h) _____ (c) _____ (w)_____

Place of Work _____

Parent #2 Info:

Name _____

Address_____

Phone# (h) _____(c)_____(w)_____

Place of Work _____

Name and Phone # of two **emergency contacts** (other than parents):

Name Phone Relationship

1._____

2. _____

Child's Physician_____ Phone_____

Physician's Address _____

Name of Health Insurance Carrier for child_____

Policy Number _____

Subscriber's Name _____
(Medical care, if required, will be paid for by parents)

(over, please)

About your child:

• Does your child have any food/dietary/contact/environmental allergies? Yes No

If yes, please list: _____

• Does your child have any medical concerns--special needs, medications, etc.? Yes No

If yes, please explain:_____

• Does your child receive any outside support--Early Intervention, Intermediate Unit, Lenape Valley, etc? Yes No

If yes, please explain:_____

• Does your child receive Speech Support? Yes No

• Does your child speak another language at home? Yes No If yes, please explain _____

• Does your child receive Physical/Occupational Therapy? Yes No

• Does your child have an IFSP/IEP? Yes (must submit copy to BBLC) No

• In addition to BBLC, will your child be attending any other group learning/daycare facilities? Yes No

If yes, please indicate name _____

• Any further information that may help us best serve your child? _____

_____

_____

My signature indicates my consent for emergency medical care: _____

My signature indicates that the above information is accurate:_____

Today's Date _____