

Building Blocks Learning Center

Emergency Contact/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: _____

- Is an Epi-Pen prescribed for your child? Yes No

- 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

- Has your child previously attended a school/group learning facility? Yes No

If yes, which school/group learning facility? _____

- 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 _____