Building Blocks Learning Center, Inc.

Emergency Contact/Information Form

Please do not leave any sections blank.

Name of Child _____ DOB _____

Parent/Guardian #1 Info:

Name _____

Address_____

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

Place of Work _____

Parent/Guardian #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 _____ Group Number _____

Subscriber's Name _____
(All 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-- medications, conditions, 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 _____

- Who does your child live with?_____

_____

- 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 _____