



Wings Early Childhood Education Center

Emergency Information

Today's Date: _____

Child's Name: _____ Date of Birth : _____

Mother's Name: _____ Last 4 Digits of SS #: _____ Phone: Home: _____ Work/Cell: _____

Father's Name: _____ Last 4 Digits of SS #: _____ Phone: Home: _____ Work/Cell: _____

Local Emergency Contact / Authorization Pick up Contact #1

Name: _____ Phone: Home: _____ Work/Cell: _____

Address: _____ Last 4 Digits of Social Security #: _____

Local Emergency Contact / Authorization Pick up Contact #2

Name: _____ Phone: Home: _____ Work/Cell: _____

Address: _____ Last 4 Digits of Social Security #: _____

Local Emergency Contact / Authorization Pick up Contact #3

Name: _____ Phone: Home: _____ Work/Cell: _____

Address: _____ Last 4 Digits of Social Security #: _____

Who may NOT pick up this child: _____

Documented Reason Why: _____

Names of individuals authorized by family to have access to health information about my child:

Legal Parent/ Guardian Signature _____ Date: _____

Food Allergies or other Special Needs: _____

First Aid

In the event of a medical emergency involving this child, I hereby give Wings permission to render emergency aid including, but not limited to, having him/her transported for care by ambulance if any of the above cannot be contacted.

Legal Parent/ Guardian Signature _____ Date _____

Child's Doctor

Name: _____ Phone: _____

Child's Dentist

Name: _____ Phone: _____

Emergency Care

In the event of an emergency in which I cannot be reached, the physician listed above and the clinic, EMTs, or hospital are hereby authorized to provide emergency care deemed necessary for my child.

I understand that I am responsible for all medical costs incurred due to an accident or injury on Wings premises.

Do you have health insurance? Yes _____ No _____ Insurance Company Name _____

Name on Insurance Card: _____ Member ID: number _____

Parent/Guardian Signature _____

Date _____