COMMUNITY ACTION TEAM, INC.
CHILD & FAMILY DEVELOPMENT PROGRAMS
Emergency Form

Child's Name:_____ Birth Date: _____

Parent/Guardian Information		
Parent/Guardian Name (Primary)	*Address*	
Home Phone	*Cell Phone*	*Email*
Parent/Guardian Name (Secondary)	*Address*	
Home Phone	*Cell Phone*	*Email*

Child Care Provider Contact Information		
Name	*Address*	*Phone*

Emergency Contact Person(s) authorized to release child to (other than parent)	
Name	Phone

Person(s) child CANNOT be released to	
Name	Name

Medical Information		
Physician	Dentist	Hospital
Child's Insurance Provider	Asthma	Date of child's last tetanus shot
	□ Yes □ No	
Medical Conditions (list)	Ongoing Medications (list)	Allergies (list)

Notification of a Medical Emergency
In the event of a medical emergency, Community Action Team staff will administer basic first aid and if necessary, 911 will be called. I consent for the emergency contact person listed above to **ACT ON MY BEHALF** if I'm unavailable. I agree to review and update this information whenever a change occurs.

Parent/Guardian Signature/Date	*Parent/Guardian Signature/Date*

Updates				
Date/Initials	Date/Initials	Date/Initials	Date/Initials	Date/Initials