EMERGENCY FORM

Check the meal(s) that your child receives: BF AM LUN PM_ SUP

INSTRUCTIONS TO PARENTS:

- (1) Complete all items on this side of the form. Sign and date where indicated.(2) If your child has a medical condition, which might require emergency medical care. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

iliu s ivame			Last	Birth Da First	ate	
rollment Date			Hours & Days of Expecte	d Attendance		
ild's Home Address						
	Street/Apt.#		City		State	Zip Code
Parent/Guardian Na	me(s)	Relationship		Phone Num	ber(s)	
			ce of Employment:	C:		H:
		 W:				
			ce of Employment:	C:		H:
		W:				
d's Email			Mom's Email			
me of Person Authorized to	Pick Up Child					
dress		Last		First	[Relationship to Chi
Street/Ap	t.#		City	State	Zip Code	
NUAL UPDATES (Initials/	Date)	(Initials/Date)	(Initials/Date)		ials/Date)	
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en parents/guardians canr Name Address Street/Ap Name Address Street/Ap	not be reached, it.# f Health Care it.#	Last Last Last cal attention, your child wi	city	ck up the child in an ine (H)	emergency:(W) State(W) State State	Zip Code

INSTRUCTIONS TO PARENT/GUARDIAN:

- (1) Complete the following items, as appropriate, if your child has a condition(s), which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name:	Date of Birth:
Medical Condition(s):	
Medications currently being taken by your child:	
Allergies/Reactions:	
EMERGENCY MEDICAL INSTRUCTIONS:	
(2) If signs/symptoms appear, do this:	
(3) To prevent incidents:	
OTHER SPECIAL MEDICAL PROCEDURES THAT M	MAY BE NEEDED:
COMMENTS:	
Note to Health Practitioner:	
If you have reviewed the above information, p	please complete the following:
Name of Health Practitioner	Date
Signature of Health Practitioner	() Telephone Number