Tolland Family Resource Center
Emergency Information

Child's Name: _____

Birthdate: _____

Address: _____

Home phone: _____

Parent's Name: _____ Stepparent's Name: _____

Parent's Address: _____ Stepparent's Address: _____

Parent's Email Address: _____ Stepparent's Email Address: _____

Parent's Cell Phone: _____ Stepparent's Cell Phone: _____

Parent's Work Phone: _____ Stepparent's Work Phone: _____

Parent's Name: _____ Stepparent's Name: _____

Parent's Address: _____ Stepparent's Address: _____

Parent's Email Address: _____ Stepparent's Email Address: _____

Parent's Cell Phone: _____ Stepparent's Cell Phone: _____

Parent's Work Phone: _____ Stepparent's Work Phone: _____

If you cannot be reached, please provide 2 alternate emergency backups that we may contact.

Emergency Contact 1

Name: _____

Day Time Phone: _____

Cell Phone: _____

Emergency Contact 2

Name: _____

Day Time Phone: _____

Cell Phone: _____

In case of an emergency the Family Resource Center is authorized to contact the either parent or physician. Please number in order preference. In case none of the listed can be contacted, your child will be taken to the nearest appropriate hospital emergency room.

_____ Parent #1 _____ Parent #2 _____ Physician Name: _____

Physician Phone: _____

Child lives with ___ both parents ___ Parent #1 ___ Parent #2 ___ Other: _____

Please list the name and phone number of the insurance company the child is covered by.

_____

Please answer all medical questions.

Does your child have asthma? ___ yes ___ no

(If yes, please specify treatment and medications required.)

_____

Does your child use daily medications? ___ yes ___ no

(If yes, please specify medications.)

_____

Does your child have any known allergies? ___ yes ___ no

(If yes, please specify food drug, environmental and animal.)

_____

Does your child have diabetes, seizures, a heart condition or any other serious medical condition? Please specify ___ yes ___ no

_____

Signature of Parent / Guardian _____