Shepherd of the Valley Preschool

Emergency Information and Authorized Pick Up Information

Child's Name_____Home Phone_____

Date of Birth_____

Person/s to call in the event of an emergency and are Authorized to Pick Up: (Please provide at least 4) If there are more people than spaces available, please add to the back of the form

1. **Parent 1/Guardian**_____ Cell Phone_____

Email address: _____ Other Phone_____

Occupation/Business Name: _____

2. **Parent 2/Guardian**_____ Cell Phone_____

Email address: _____ Other Phone_____

Occupation/Business Name: _____

3. **Authorized Person**_____ Cell Phone_____

Address_____ Other Phone_____

4. **Authorized Person**_____ Cell Phone_____

Address_____ Other Phone_____

5. **Authorized Person**_____ Cell Phone_____

Address_____ Other Phone_____

6. **Authorized Person**_____ Cell Phone_____

Address_____ Other Phone_____

*Address is a requirement of my state license for all people authorized to pick up students.

Name of Child's Doctor_____ Phone_____

Address_____

Emergency Hospital Preference_____Phone_____

Address_____

Name of Child's Dentist_____Phone_____

Address_____

Is there anyone your child SHOULD NOT have contact with? _____ No _____ Yes

If yes, who? _____

I give my permission for Shepherd of the Valley Preschool to take whatever steps may be necessary to obtain emergency medical care if warranted.

Signed_____Date_____
(Parent 1 or Legal Guardian)

Signed_____ Date_____
(Parent 2 or Legal Guardian)

Notification of Allergies **(Complete only if applicable)**

Allergies_____

Reaction_____

I have supplied an epi pen to Shepherd of the Valley Preschool and give them the right to use it on my child if necessary.
____Yes ____No

Signed_____ Date_____
(Signature of Parent of Legal Guardian)