CARE
Reach fullest potential!

# Emergency Contact Form

**Date:** _____

**Client:** _____
**Last Name** **First Name** **Middle Name** **Date of Birth**

**Allergies/Medical Conditions?** Yes/No:_____
If yes, please list all allergies and any specific medical interventions that may be necessary to address these needs: _____

**Current Medication(s) we should be aware of?** Yes/No: _____
If yes, please list all medications we should be aware of:

_____

**Parent/Caregiver Name(s):** _____

**Home Address:** _____

_____ _____ _____
**City** **State** **Zip Code**

**Cell Phone**: (____) _____ **Home Telephone:** (____) _____

Please list the people you would like to be notified in case of emergency, including a local contact.

**IN CASE OF EMERGENCY CONTACT (*authorized to make a decision in case of an emergency*):**

**(1) Name & Relationship** _____

_____
Street Address City State Zip Code

Telephone: (____) _____ Daytime Phone #: (____) _____

**Is this person allowed to pick up/ drop off_____ for center-based services? (Yes / No)**

**(2) Name & Relationship** _____

_____
Street Address City State Zip Code

Telephone: (____) _____ Daytime Phone #: (____) _____

**Is this person allowed to pick up/ drop off_____ for center-based services? (Yes / No)**

**Parent/Guardian Printed Name:** _____

**Parent/Guardian Signature:** _____