**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Street Address City State Zip Code

Telephone: ( ) Daytime Phone #: ( )

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

1. **Name & Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**