



EMERGENCY CONTACT FORM

Child's Name Maya Reddy Konatam Date of Birth 05/25/2017
Child's Address 1609 Pleasant St #209 Lauderdale MN 55108

EMERGENCY CONTACT INFO

Parent/Guardian #1

Name Ravindhar Reddy Konatam
Address (if different than child's)

E-mail ravindhar.rddy@gmail.com
Phone (c) 612-442-0405 Phone (w) 651-490-8235
Phone (h) _____

Parent/Guardian #2

Name Shalini Bangalore Subramani
Address (if different than child's and guardian #1)

E-mail shalumani@gmail.com
Phone (c) 612-442-0405 Phone (w) _____
Phone (h) _____

Emergency Contact #1

(to whom child may be released if parent/guardian is unavailable)

Name Roshini
Address 1314 Marquette Ave 703 Minneapolis MN 55403

Relationship Aunty Phone (c) 612-402-4655
Phone (w) _____ Phone (h) _____

Emergency Contact #2

(to whom child may be released if parent/guardian is unavailable)

Name Swati dora
Address 1314 Marquette Ave 703 Minneapolis MN 55403

Relationship Aunty Phone (c) 763-406-2946
Phone (w) _____ Phone (h) _____

CHILD'S USUAL SOURCE OF MEDICAL CARE

Physician Dr. Patricia Hickey
Address 2525 Chicago Ave, Minneapolis, MN 55404

Phone _____
Dentist NA
Address _____

Phone _____

Hospital _____
Address _____

Phone _____
Child's Health Insurance CIGNA
Subscriber's Name CIGNA

Specific Instructions of Special Conditions, Disabilities, Etc.

Write none if none apply.

Allergies

Write none if none apply.

None

As the parent/legal guardian, I give consent to SonShine Learning Center to administer to my child emergency first aid by the program staff. I understand that, if necessary, 911 will be called and my child may be transported to receive emergency care. I understand that I will be responsible for all emergency transportation and any charges not covered by insurance.

I give consent for the emergency contact persons listed above to act on my behalf until I am available.

I agree to notify SonShine Learning Center if any of the above information changes.

Parent/Guardian #1 _____ Date _____
Parent/Guardian #2 _____ Date _____