CHILD CARE LICENSING AND CHILD CARE ASSISTANCE PROGRAMS
Child Care Program Office

CHILD EMERGENCY INFORMATION

Items indicated with an * are required by Child Care Licensing regulations 7 AAC 57, Medical Administration regulations 7 AAC 10.1070, and/or Child Care Assistance regulations 7 AAC 41.

CHILD'S INFORMATION

*Child's Name:	*Date of Birth:
Siblings Enrolled? ☐ Yes ☐ No Name(s):	Any Custody Arrangements/Restrictions ☐ Yes ☐ No Special Instructions/Comments:

PARENT(S) OR LEGAL GUARDIAN(S) INFORMATION

*Name:	*Relationship:	Name:	Relationship:
*Cell Phone: Email Address:	*Home Phone:	Cell Phone: Email Address:	Home Phone:
Physical Home Address:		Physical Home Address:	
Place of Employment/Other:		Place of Employment/Other:	
*Employment or Other Main Phone:		Employment or Other Main Phone:	

PERSONS AUTHORIZED TO PICK-UP CHILD

List the names and phone numbers of persons who can pick up your child. You must include at least one name and phone number of an individual who can assume responsibility for your child if you cannot be reached immediately in an emergency. Clarify whether these individuals can pick up the child in emergency situations and/ or at other routine times.

Name:	Daytime Phone:	Cell:	☒ Emergency ☐ Routine
Name:	Daytime Phone:	Cell:	☐ Emergency ☐ Routine
Name:	Daytime Phone:	Cell:	☐ Emergency ☐ Routine
Name:	Daytime Phone:	Cell:	☐ Emergency ☐ Routine

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MEDICAL INFORMATION AND RELEASE FOR MEDICAL CARE

Items indicated with an * are required by Child Care Licensing regulations 7 AAC 57, Medical Administration regulations 7 AAC 10.1070, and/or Child Care Assistance regulations 7 AAC 41.

Child's Name:	Child Care Facility: Mt. Edgecumbe Preschool

*Health Concerns

☐ My child has no health concerns, including allergies or medications

-OR-

☐ My child has the following health concerns:

Medication, medical, or other treatments: _____

Allergies (including foods, drugs, others): _____

Additional Needs/Concerns (ex: dietary, health related services, special needs, behaviors) _____

Medication Administration Authorization Form on File (if applicable): ☐ Yes ☐ No

PREFERRED PHYSICIAN AND MEDICAL FACILITY INFORMATION

*Physician's Name:	Physician's Phone:
*Preferred Hospital: SEARHC	

I verify the information contained on this record is correct and complete. I hereby give the permission for emergency medical treatment, including emergency transportation to a health care facility, for my child. I understand that every effort will be made to locate me or my child's other parent or legal guardian as soon as possible, and that I will assume the costs associated with emergency medical care/transportation, if needed. I also understand it is my obligation to keep my child care provider informed of my whereabouts. This authorization remains valid until revoked by myself.

* _____ * _____

Signature of Parent or Legal Guardian — Date Signed

*This information must be reviewed and updated by the child's parent at least semi-annually and when new information becomes available.

Date & Initial		Date & Initial		Date & Initial		Date & Initial		Date & Initial	