

**St. Louis Park Community Education – Early Learning Program
Emergency Health Form**

Today's Date:

Child's Name: _____ Nickname: _____

Child's Birth Date: _____ Male _____ Female _____

Child's Home Address: _____

Child Living With: _____ Parent(s) _____ Guardian(s) _____ Step-Parent(s) _____ Foster Parent(s) _____ Other _____

Parent/Guardian Name (1): _____

Primary Phone: _____ Alternate Phone: _____

Email (required): _____

Parent/Guardian Name (2): _____

Primary Phone: _____ Alternate Phone: _____

Email (required): _____

Name of person to contact if parent(s) cannot be reached in an emergency:

Name: _____ Relationship: _____

Home Phone: _____ Alternate Phone: _____

Is there anyone who may NOT pick up your child? _____

Language Spoken at Home: _____ Parent(s) Native Country: _____

Does your child have Allergies? _____ Yes _____ No

Asthma? _____ Yes _____ No

Other Allergies (bees, medications, etc.)? _____

Food Restrictions/Allergies? _____

*Please Note: You must complete the **Food Allergy Action Plan** and return it to the teacher before your child attends class.*

Major Illnesses/Surgeries: _____

Any other health concerns we should be aware of? _____

Physician's Name: _____ Clinic: _____

Phone: _____

Dentist's Name: _____ Clinic: _____

Phone: _____

Hospital Preference: _____ Phone: _____

In case of emergency, illness, or accident to the child named above, the staff will attempt to first contact parent/guardian and second the emergency contact listed above. If that contact cannot be made, program personnel will call the physician authorized by the parent or 911 Emergency Services System. If child needs to be transported to the nearest hospital, it is at the parent's experience.

I hereby grant permission to the staff to take whatever emergency measures are judged necessary for the care and protection of my child.

Signature of parent or guardian: _____ Date: _____

06/24/20 HDM