EMERGENCY FORM

Student's Name: _____

How will we be able to reach you in case of an emergency with your child?

_____	_____	_____	_____
Father	**Home Phone**	**Cell Phone**	**Work Phone**
_____	_____	_____	_____
Mother	**Home Phone**	**Cell Phone**	**Work Phone**

Please list below, persons we may contact who are authorized by you who will assume responsibility for your child if you cannot be reached in case of an emergency situation.

Name:	**Name:**	**Name:**
Relationship:	**Relationship:**	**Relationship:**
Phone:	**Phone:**	**Phone:**
Address:	**Address:**	**Address:**

EMERGENCY MEDICAL TREATMENT

European Academy of Early Education has my permission to consult the physician named in case of an emergency and I cannot be reached. I agree to be financially responsible for the costs of medical treatment obtained under the authorization.

Parent Signature: _____ Date: _____

CRITICAL EMERGENCY MEDICAL TREATMENT

In case of an immediate or critical emergency, EAEE has my permission to contact 911.

Parent Signature: _____ Date: _____

Are there any health problems we should be aware of? Yes:☐ No:☐ If yes, please list:

_____

_____

Child's Physician's Name: _____

Phone:_____ Preferred Hospital:_____

_____ **Date:_____**

Notary