Close To My Heart
Early Childhood Development Center
1740 Van Dyke Street
St. Paul, MN 55109
651-307-1492

Emergency Contact Form

Child's First, Middle & Last Name: ______________________________ **Birth Date**: ____________
Mother/Guardian First, Middle & Last Name: ______________________________ **Email**: ____________
Address: ______________________________ **Phone**: ____________
Company Name & Address: ______________________________
Hours: ______________________________ **Phone& Ext.** ____________
Cell Phone: ______________________________ **Pager**: ____________
Father/Guardian First, Middle & Last Name: ______________________________ **Email:** ____________
Address: ______________________________ **Phone:** ____________
Company Name & Address: ______________________________
Hours: ______________________________ **Phone& Ext**. ____________
Cell Phone: ______________________________ **Pager**: ____________

EMERGENCY CONTACTS: In case child listed above becomes ill or is injured and I(Parent/Guardian) cannot be contacted, CTMH has my permission to contact and release my child to the custody of one of the following.

Name: ______________________________ **Relationship**: ____________
Address: ______________________________ **Phone**: ____________
Name: ______________________________ **Relationship**: ____________
Address: ______________________________ **Phone**: ____________
Name: ______________________________ **Relationship**: ____________
Address: ______________________________ **Phone**: ____________
Name: ______________________________ **Relationship**: ____________
Address: ______________________________ **Phone**: ____________
Family Physician's Name: ______________________________ **Phone**: ____________
Clinic Name & Address: ______________________________
Child's Health Card #: ______________________________
Hospital you prefer: ______________________________
Are there any known illness, surgery, injuries, allergies, health or medical conditions that the Provider should be made aware of? Circle YES or NO If yes, please describe:

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SPECIFIC INSTRUCTIONS OF PARENT/GUARDIAN: (i.e. allergies, ongoing medication, restrictions for treatment, etc.): ______________________________

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PARENT'S CONSENT: The information on this form will be used in emergency situations. School personnel, CTMH employees, health service staff, bus aides and drivers will have the information in the event of an emergency. If at any time, due to such circumstances as accident, sudden illness, or emergency and medical treatment is required, this card will be given to the necessary personnel including a private physician, hospital, anesthetic, if necessary, or hospital. I give permission to Close To My Heart to make whatever emergency measures as judged necessary for the care and protection of my child while under the supervision of the program. In case of medical emergency, I understand that my child will be transported to St. Paul Children's Hospital by the local emergency unit for treatment at my expense, if the local emergency source (police/rescue squad) deems it necessary. In the event of accidental ingestion, I understand that Close To My Heart will contact the Poison Control Center. I give permission for the staff to administer Syrup of Ipecac to my child if directed by the Poison Control Center. **I herby authorize the program to act on my behalf in case of an emergency.**

______________________________ ______________________________ ____________
Signature of Parent/Guardian **Print Name** **Date**