

Emergency & Medical Information

1. Emergency Information (indicate 2 individuals who may be called in the event a parent cannot be contacted)

Name/Relationship: _____ Telephone: () _____ cell: () _____

Name/Relationship: _____ Telephone: () _____ cell: () _____

2. Physician

Name: _____ Telephone: () _____

3. Dentist

Name: _____ Telephone: () _____

4. Insurance Information

Company: _____ Group No: _____ Policy No: _____

ALLERGIES: (Substances allergic to, reactions, and treatment) _____

In the case of emergencies requiring immediate medical attention, your child will be taken to the nearest hospital emergency room. Your signature below authorizes the responsible person at the child care facility to have your child transported to that hospital.

Additional Information

Please indicate below child's strengths and weaknesses (physical, emotional, or intellectual). In addition, please provide any other information that may be pertinent to the education, growth, and development of the student (attach additional sheets if necessary).

Parent or Guardian Signature

Date

Parent or Guardian Signature

Date

**THIS FORM CAN BE SUBMITTED VIA EMAIL TO badler@shaaretefila.org OR BY MAIL TO:
Gates of Discovery/The Rose and George Teller Preschool of Shaare Tefila
16620 Georgia Avenue, Olney, MD 20832**