Geist Orchard
COOPERATIVE PRESCHOOL

# EMERGENCY INFORMATION

**Name of Child** _____ **Gender**_____ **Birthdate**_____

**Mother or guardian**_____ Home Phone_____

Home Address/City/State/Zip _____

Business Name_____ Work Hours_____

Business Address/City/State/Zip_____

Work Phone_____ Cell Phone_____ E-mail_____

**Father or guardian**_____ Home Phone_____

Home Address/City/State/Zip _____

Business Name_____ Work Hours_____

Business Address/City/State/Zip_____

**Please list the name of a friend or relative who may be reached in case of an emergency. This individual may be asked to pick your child up from GOCP in the event of an illness, injury or emergency. It is a State Requirement that a LOCAL emergency person is listed.**

Name _____Relationship to child_____

Address/City/State/Zip_____Phone_____

## PERSONS AUTHORIZED TO PICK UP MY CHILD

**Authorized individuals will be required to show picture identification when picking up a child from GOCP. Under no circumstances will a child be released to anyone not known to the center without authorization from parents or guardians.**

1) Name _____Relationship to child_____

Address/City/State/Zip_____Phone_____

2) Name _____Relationship to child_____

Address/City/State/Zip_____Phone_____

If a parent is denied permission to pick-up a child, please provide parent's name _____
and a copy of the court order.

**Signature of Parent or Legal Guardian**_____ **Date**_____

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# EMERGENCY MEDICAL AUTHORIZATION

I agree, and by my signature give consent that in case of an accident, injury or illness of a serious nature, my child will be given emergency medical care. I understand that I will be contacted immediately, or as soon as possible, should I be away from the phone numbers given with this form.

Child's Name _____Date of Birth_____

Child's Physician _____ Phone _____

Address/City/State/Zip_____

Child's Dentist _____ Phone _____

Address/City/State/Zip_____

Do you have a preference regarding the hospital we would take your child to in case of a medical emergency?

Yes_____ No_____ If yes, please indicate your hospital of preference _____

**Signature of Parent or Legal Guardian**_____ **Date**_____

**REMINDER: Please update information contained on this form when changes occur.**