



THE MOUNT CARMEL Early Childhood Center

The Mount Carmel Early Childhood Center Emergency Form

Child's Name _____ Gender _____ D.O.B _____

Allergies/ Special Health Considerations _____

Address _____ Zip _____

Primary Email _____

Parent #1 _____ Home _____ Work _____ Cell _____

Parent #2 _____ Home _____ Work _____ Cell _____

Persons, including parents, authorized to pick up child, their phone numbers and relationship to child. The Mount Carmel Early Childhood Center will dismiss your child at the end of each school day according to the information you provide below. If the information changes you must notify TMCECC immediately.

Name _____ Cell _____ Relationship _____

Name _____ Cell _____ Relationship _____

Name _____ Cell _____ Relationship _____

Name _____ Cell _____ Relationship _____

Child's Physician _____ Phone _____

Child's Dentist _____ Phone _____

Child's Health Insurance _____ Policy # _____

Local Emergency Contact – if your child becomes ill and must be sent home from school and a parent cannot be reached:

Name _____ Cell _____ Relationship _____

Name _____ Cell _____ Relationship _____

Authorization: In the event that I or the above mentioned emergency contacts cannot be reached. I authorize The Mount Carmel Early Childhood Center to designate a doctor and/or hospital to initiate appropriate emergency medical services for my child/children.

Signature _____ Date _____ Relationship to child _____