

**CENTRAL LUTHERAN EMERGENCY INFORMATION CONSENT FORM**

Child's Name: \_\_\_\_\_ Birthdate \_\_\_\_\_  
 (Please Print) Last First Initial

Parent(s)/Guardian(s): \_\_\_\_\_

name \_\_\_\_\_ name \_\_\_\_\_

address \_\_\_\_\_ address \_\_\_\_\_

home phone wk phone cell phone \_\_\_\_\_ home phone wk phone cell phone \_\_\_\_\_

employer \_\_\_\_\_ employer \_\_\_\_\_

employer's address \_\_\_\_\_ employer's address \_\_\_\_\_

social security number \_\_\_\_\_ social security number \_\_\_\_\_

With whom does the child live? \_\_\_\_\_

**EMERGENCY CONTACTS \*\*REQUIRES NAME(S), ADDRESSES, & PHONE NUMBERS\*\***  
 Please list two different emergency contacts or people who are willing to assume responsibility if parent or guardian cannot be reached. They are authorized to pick up my child.

name address home # work # cell phone# \_\_\_\_\_

name address home # work # cell phone # \_\_\_\_\_

**MEDICAL INFORMATION**

physician address phone # \_\_\_\_\_

Hospital Preference: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 name, city & phone # \*child care plan on file

Dentist \_\_\_\_\_ Special Needs: \_\_\_\_\_  
 name, address & phone # \*child care plan on file

Other Medical Information \_\_\_\_\_

I give permission to Central Lutheran School to take whatever emergency measures judged necessary for the care and protection of my child while under their supervision. In case of a medical emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency resource deems it necessary. It is understood that in some medical situations, the staff will need to contact the local emergency resource before the parent, child's physician, and/or adult acting on the parent's behalf.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

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I hereby grant permission for:

- my child to use all of the play equipment and participate in all of the activities of the programs.
- my child to leave the school premise under proper supervision for neighborhood walks or to go to nearby parks.
- my child to be photographed for public relations purposes.
- the staff to administer Syrup of Ipecac to my child \_\_\_\_\_, if directed to do so by the Poison Control Center or medical personnel.
- our names, address, and home phone number to be listed in the school directory.

Child's name: \_\_\_\_\_

(Parent(s) / Guardian(s) signature(s)

(date)

Additional Persons who authorized to: pick up my child from the center, assume responsibility for my child, and /or act on behalf of my child in an emergency if a parent/guardian cannot be reached. Names, Address, & Phone numbers MUST all be included!

| Name(s) | address | home # | work # | cell # |
|---------|---------|--------|--------|--------|
|         |         |        |        |        |
|         |         |        |        |        |

| Name(s) | address | home # | work # | cell # |
|---------|---------|--------|--------|--------|
|         |         |        |        |        |
|         |         |        |        |        |

IS THERE ANYONE WHO MAY NOT PICK UP YOUR CHILD? WHO? (MN STATUES REQUIRE A RESTRAINING ORDER BE ON FILE WITH THE CENTER, IN ORDER TO RESTRICT A BIOLOGICAL PARENT FROM CONTACT WITH (INCLUDING PICKING UP) THEIR CHILD. THIS IS A BINDING LEGAL DOCUMENT WHICH REQUIRES A LEGAL DOCUMENT INCLUDING A JUDGE'S SIGNATURE, TO RESCIND THIS ORDER.

(RESTRAINING ORDER ON FILE?... \_\_\_\_\_)

FAMILY INFORMATION

Child's sex \_\_\_\_\_ Child's place of birth \_\_\_\_\_

Religious affiliation : Mother \_\_\_\_\_ Father: \_\_\_\_\_

Home Church: \_\_\_\_\_ Is child baptized? \_\_\_\_\_ Date \_\_\_\_\_

Does child attend Sunday School? \_\_\_\_\_ Is yes, where? \_\_\_\_\_

List all children in the family:

Name \_\_\_\_\_ Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

PARENTS' MARITAL STATUS:

MARRIED ( ) DIVORCED ( ) SEPERATED ( ) SINGLE ( ) WIDOW / WIDOWER ( )