

**EMERGENCY CONTACT FORM – Music and Movement, Parent and Tot**

*This form will be used by Northfield Community Nursery School in the event of a medical emergency which requires the school and/or medical personnel to contact someone other than the parent/caregiver who attends the Parent and Tot class with the child. It contains important information about you and/or your child that may be needed in an emergency situation, and provides the fastest way to reach parents and/or other individual in the event of an emergency.*

**Child's name:** \_\_\_\_\_ Birthdate: \_\_\_\_\_

Any known allergies or medical conditions: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Physician's name: \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_

1<sup>st</sup> person to contact in the event of emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Home phone: \_\_\_\_\_

Name and place of business if applicable: \_\_\_\_\_

2nd person to contact in the event of emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Home phone: \_\_\_\_\_

Name and place of business if applicable: \_\_\_\_\_

**Adult participant's name:** \_\_\_\_\_

Any known allergies or medical conditions: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Physician's name: \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_

1<sup>st</sup> person to contact in the event of emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Home phone: \_\_\_\_\_

Name and place of business if applicable: \_\_\_\_\_

2nd person to contact in the event of emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Home phone: \_\_\_\_\_

Name and place of business if applicable: \_\_\_\_\_

*I hereby authorize school officials to seek immediate medical attention with Northfield Paramedic Emergency Service in an emergency situation involving my above named child and/or adult. I agree to accept all financial responsibility incurred by such action which may include transportation to and/or treatment at Glenbrook Hospital, Glenview, IL.*

\_\_\_\_\_  
(parent/guardian name)

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)