Temple Ohav Shalom Center for Early Learning
Emergency Information

Child's Name _____ _____, **usually called** _____ **Sex**____ **Birth date** _____
Last Name **First Name**

Address_____**City & Zip**_____

Parent/Guardian: Relationship to Child _____ **Parent/Guardian: Relationship to Child** _____

_____ _____ __ _____ _____
Last Name **First Name** **Last Name** **First Name**

Contact phone # _____ **Text ? (Y/N)** _____ **Contact phone #** _____ **Text ? (Y/N)** _____

Contact email _____ **Contact email** _____

Contact work # _____ **Contact work #** _____

Emergency Contacts:

Name	Contact phone #	Text? (Y/N)	Relationship to child
_____	_____	_____	_____
_____	_____	_____	_____

Please list any allergies, medical or dietary restrictions _____

_____

Physician's Name _____ **Phone** _____

Please list all persons other than parent/guardian who have permission to pick up your child from school:

Name	Phone No.	Relationship to child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If neither parent/guardian can be contacted in the event of serious injury or illness, I authorize Temple Ohav Shalom to take such emergency action as deemed necessary, including the transportation of my child to a hospital or medical provider with the use of an ambulance when advisable.

_____
Parent/Guardian signature **Date**