Minnesota JCC

2025/2026 Program Year

# Student Emergency Form *(page 1 of 2)*

Please fill out the entire form as required by licensing regulations. In order to ensure compliance and provide the best care for your child, it is essential that we have all necessary information. Thanks!

Child's Name_____ Birthdate_____Date of last DPT_____

Child's Address/City/Zip_____

Allergies/significant medical information_____

**Parent/Guardian 1 Name (First & Last)**_____

Address/City/Zip _____

Home Phone_____ Cell Phone _____

Work Phone_____ Email _____

**Parent/Guardian 2 Name (First & Last)**_____

Address/City/Zip _____

Home Phone_____ Cell Phone _____

Work Phone_____ Email _____

**PHYSICIAN**

Name_____

Phone_____

Address_____

**DENTIST**

Name_____

Phone_____

Address_____

**ALLERGIES/SPECIAL NEEDS**

Food and/or Medication Allergies/significant _____

Other Allergies_____

Additional Medical Concerns (asthma, etc.) _____

My child will need medication administered during the day:

Medication and Dosage_____ Time_____

Additional information_____

*please complete other side*

**TWO NON-PARENT/GUARDIAN EMERGENCY CONTACTS ARE REQUIRED.**

**1. Emergency contact/authorized individual who may pick up child:**

Name_____ Relationship_____

Phone_____

Address _____

**2. Emergency contact/authorized individual who may pick up child:**

Name_____ Relationship_____

Phone_____

Address _____

**3. Emergency contact/authorized individual who may pick up child: (optional)**

Name_____ Relationship_____

Phone_____

Address _____

People who may **NOT** pick up my child_____

**Emergency information must be updated once yearly.**

If parent and personal physician cannot be reached or are delayed in arriving, in the event of an emergency, I authorize appropriate hospital or my doctor's hospital named above to treat my child. The emergency contacts listed above are authorized to pick up my child.

**Parent/Guardian's Signature** _____

**Date** _____