

**ST. VINCENT DE PAUL PRESCHOOL****6828 Old Reid Road—Charlotte, NC 28210****704-644-4656****EMERGENCY CONTACT FORM****20\_\_ - 20\_\_****PLEASE PRINT**CHILD'S NAME: \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Date of Birth \_\_\_\_\_

IN CASE OF EMERGENCY: Best Contact Phone Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

(This will be honored whenever possible, but in accordance with the prevailing circumstances, it will be left to the discretion of the adult in charge.)

Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

**ALLERGIES:** My child has the following allergies as listed (peanuts, medication, bee sting, pets, other food, etc.):  
\_\_\_\_\_  
\_\_\_\_\_My child has the following serious condition/s which necessitate/s immediate medical attention should it/they occur during school hours:  
\_\_\_\_\_  
\_\_\_\_\_**I agree that the Preschool director or teacher may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately.**\_\_\_\_\_  
Date\_\_\_\_\_  
Mother's signature\_\_\_\_\_  
Father's signature