|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| DARTMOUTH  COLLEGE  CHI LD CARE  CENTER | **DCCCC Emergency Medical Care Permission** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Child’s Name: | |  |  | | | | | | | |  | D.O.B.: |  | |
| Date of DCCCC Enrollment: | | | |  |  | | | | |  | |  | |  |
|  | |  | | | |  |  | | | | |  | |  |
| Parent/Guardian Name: | |  | | | | | | |  |  | | | | | |
| Home Address: | |  | | | | | | |  |  | | | | | |
| Email: | |  | | | | | | |  |  | | | | | |
| Employer: | |  | | | | | | |  |  | | | | | |
| D.C. Dept. (if applicable): | |  | | | | | | |  |  | | | | | |

Please list all phone numbers where you can be contacted in case of illness. **List them in the order in which they should be contacted and whether a call or text is preferred.**

|  |  |  |  |
| --- | --- | --- | --- |
| Phone Number Order | Phone Number | Text or Call | Parent/Guardian Associated with This Number and Notes |
| 1st Number to Use |  |  |  |
| 2nd Number to Use |  |  |  |
| 3rd Number to Use |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| In case my child is sick and needs to be taken home, I prefer to be reached by (please rank the following): | Phone Call: |  | Text: |  | Email: |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Allergies: |  | | | |  | Reaction: | | |  | | | | | | | |
| Health Concerns: | | |  | | | | | | | | | | | | | |
| Medications Used Routinely: | | | |  | | | | | | | | | | | | | |
| Doctor’s Name: | |  | | | | | | | |  | | Phone: | |  | | |
| Health Insurance Company: | | | |  | | | | | | |  | | Insured’s Name: | | |  | |
| Group Number: NynNuNumNuNumNumber: | |  | | | | |  | Identification Number: | | | | | | |  | |

If I/we cannot be located, the following people are authorized to assume temporary care of my child:

**NOTE: At least one person listed MUST have a local address.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | |  |  | |
| Relationship to Child: |  | |  |  | |
| Primary Phone: |  |  |  |  |  |
| Alternate Phone: |  |  |  |  |  |

**I/we authorize DCCCC staff to:** 1. Administer simple first aid when necessary

2. Obtain emergency medical care and transportation

3. Contact my child’s physician (above).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Signature of Parent/Guardian: |  |  |  | Date: |  |  |
| Signature of Parent/Guardian: |  |  |  | Date: |  |  |
|  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FOR OFFICE USE ONLY -** Parent/Guardian must review this information annually, make necessary changes, and initial and date below to verify that the information is current. | | | | | | | | | | | | | | | |
| Initials: |  |  |  | Date: |  |  |  | Initials: |  |  |  | Date: |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Initials: |  |  |  | Date: |  |  |  | Initials: |  |  |  | Date: |  |  |  |
|  | | | | | | | | | | | | | | | |