

Connecticut College
Child Development Lab School

Connecticut College Box 5215, 75 Nameaug Avenue, New London, CT 06320
Telephone (860) 439-2920 Fax (860) 439-5317

EMERGENCY FORM

Child's Full Name: _____ Date of Birth: _____ M or F
(First, Middle, Last)

Names of parents/guardians _____

Address: _____

Parent/guardian's home/work/cell phone: _____

Parent/guardian's home/work/cell phone: _____

Who should we call first? _____

Email Addresses 1) _____ 2) _____

Medical coverage and number: _____

Physician's name: _____ Phone: _____

Current Medications: _____

Any Allergies: No Yes (See Below) **Any Sensitivities:** No Yes If yes, please explain:

1. Allergy to: _____
What is child's reaction? _____

2. Allergy to: _____
What is child's reaction? _____

Names of persons, other than child's parents, who live close by and are readily available to provide transportation to or from school and to assist in emergency care for your child in case you cannot be contacted. (e.g. care for at home, take to the clinic or emergency room, pick up from school)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Emergency Medical Care

It is possible that an emergency could occur which could require hospital facilities. If we cannot reach you or anyone named by you to be called in an emergency, may we have your permission to take your child to Lawrence and Memorial Hospital when this is indicated? Please be assured we would make every effort to contact you first.

Yes _____ No _____ Signed: _____ Date: _____