

Emergency Contact and Medical Information

UC Merced Early Childhood Education Center

Child's Name	Date of Birth	M	F
		Sex	
<i>Parent's/Guardian's Name</i>		<i>Parent's/Guardian's Name</i>	
()	()	()	()
Home Phone	Work Phone	Home Phone	Work Phone
()		()	
Cell Phone		Cell Phone	
Address, City, ST ZIP Code		Address, City, ST ZIP Code	
Preferred email address		Preferred email address	

ADDITIONAL PERSONS TO CONTACT IN AN EMERGENCY AND/OR AUTHORIZED TO TAKE CHILD FROM THE FACILITY

<i>Primary Emergency Contact</i>	<i>Additional Emergency Contact</i>
()	()
Home Phone	Home Phone
()	()
Cell Phone	Cell Phone
Address, City, ST ZIP Code	
<i>Additional Emergency Contact</i>	<i>Out of State Emergency Contact</i>
()	()
Home Phone	Home Phone
()	()
Cell Phone	Cell Phone
Address, City, ST ZIP Code	

MEDICAL INFORMATION

Hospital/Clinic Preference	
Physician's Name	Phone Number
Dentist's Name	Phone Number
Medical Number	

FIELD TRIPS CONSENT

I give permission for my child to participate in campus walks as part of the UC Merced ECE Center Program.

Parent's/Guardian's Signature

Date

CONSENT FOR EMERGENCY MEDICAL TREATMENT-

Child Care Centers or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HERBY GIVE CONSENT TO

UC Merced Early Childhood Education Center TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH

(D.O.) OR DENTIST (D.D.S.) FOR _____

(Child's Name)

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

Child has the following Medication Allergies/Medical Conditions/Allergies

DATE

PARENT OR AUTORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE ()

WORK PHONE ()

LIC 627/(5/01) CONFIDENTIAL

For ECEC Office Use Only:

Date of Admission: _____

End Date: _____