

**INCOMPLETE FORMS CANNOT BE ACCEPTED AND WILL BE RETURNED**

**EMERGENCY CONTACT PARENTAL CONSENT FORM**

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182, 3280.124(a)(b), 3280.181 & 182, 3290.124(a)(b), 3290.181 & 182

<b>CHILD'S NAME</b>	<b>BIRTH DATE</b>
HOME ADDRESS (STREET, CITY, STATE, ZIP)	
<b>MOTHER'S NAME/LEGAL GUARDIAN</b>	<b>HOME TELEPHONE NUMBER</b>
E-MAIL ADDRESS	<b>MOBILE TELEPHONE NUMBER (CELL)</b>
HOME ADDRESS (STREET, CITY, STATE, ZIP)	
BUSINESS NAME (WORK)	<b>BUSINESS TELEPHONE NUMBER (WORK)</b>
BUSINESS ADDRESS (STREET, CITY, STATE, ZIP)	
<b>FATHER'S NAME/LEGAL GUARDIAN</b>	<b>HOME TELEPHONE NUMBER</b>
E-MAIL ADDRESS	<b>MOBILE TELEPHONE NUMBER (CELL)</b>
HOME ADDRESS (STREET, CITY, STATE, ZIP)	
BUSINESS NAME (WORK)	<b>BUSINESS TELEPHONE NUMBER (WORK)</b>
BUSINESS ADDRESS (STREET, CITY, STATE, ZIP)	
<b>EMERGENCY CONTACT PERSON(S) (in addition to parents/guardians)</b>	<b>TELEPHONE NUMBER WHEN CHILD IS IN CARE</b>
1.	1.
2.	2.
3.	3.
<b>PERSON(S) (in addition to parents/guardians) TO WHOM CHILD MAY BE RELEASED NAME &amp; ADDRESS</b>	<b>TELEPHONE NUMBER WHEN CHILD IS IN CARE</b>
1.	1.
1.	
2.	2.
2.	
3.	3.
3.	
<b>NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER</b>	<b>TELEPHONE NUMBER</b>
PROVIDER'S ADDRESS (STREET, CITY, STATE, ZIP)	
<b>SPECIAL DISABILITIES (IF ANY)</b>	<b>ALLERGIES (INCLUDING MEDICATION REACTIONS)</b>
<b>MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION</b>	<b>MEDICATION, SPECIAL CONDITIONS</b>
<b>ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD</b>	
<b>HEALTH INSURANCE CONVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS</b>	<b>POLICY NUMBER (REQUIRED)</b>
<b>PARENTS SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT</b>	
<b>OBTAINING EMERGENCY MEDICAL CARE</b>	<b>ADMIN OF MINOR FIRST-AID PROCEDURES</b>
<b>WALKS AND TRIPS</b>	<b>SWIMMING N/A</b>
<b>TRANSPORTATION BY THE FACILITY</b>	<b>WADING N/A</b>

**PERIODIC REVIEW**

SIGNATURE OF PARENT OR GUARDIAN

DATE

SIGNATURE OF PARENT OR GUARDIAN

DATE