## Tolland Family Resource Center Emergency Information

Child's Name:	
Birthdate:	
Address:	
Home phone:	
Mother's Name:	
Mother's Address:	
Mother's Email Address:	
Mother's Home Phone:	
Mother's Work Phone:	
Father's Name:	
Father's Address:	
Father's Email Address:	
Father's Home Phone:	
Father's Work Phone:	
Step Mother's Name:	
Step Mother's Address:	
Step Mother's Email Address:	
Step Mother's Home Phone:	
Step Mother's Work Phone:	
Step Father's Name:	
Step Father's Address:	
Step Father's Email Address:	
Step Father's Home Phone:	
Step Father's Work Phone:	

If you cannot be reached please provide 2 alternate emergency backups that we may contact.

Emergency Contact 1			
Name:			
Day Time Phone:			
Cell Phone:			
Emergency Contact 2			
Name:			
Day Time Phone:			
Cell Phone:			
In case of an emergency the Family Recorder preference. In case none of the li emergency room.			
Mother Father	Physician Name	:	
	Physician Pl	hone:	
Child lives with both parents	Mother Father	Other:	
Please list name and phone of insurance	e company the child is	covered by.	
Please answer all medical questions.	<u>.</u>		
Does your child have asthma?		yes no	
(If yes, please specify treatment and me	edications required.)		
Does your child use daily medications?	)	yes no	
(If yes, please specify medications.)			
Does your child have any known allergie	es?	yes no	
(If yes, please specify food drug, environ	nmental and animal.)		
Does your child have diabetes, seizures serious medical condition? Please spec		any other yes no	
Signature of Parent / Guardian			