Bainbridge Island Child Care Centers

EMERGENCY CONTACT INFORMATION **Please fill out both sides of this form completely!**

Child's Name: _____ Date of Birth: _____

Elementary School: _____ Grade: _____ Teacher: _____

Parent/Guardian's Name: _____ Email: _____

Address: _____

Home #:_____ Cell#:_____ Work #:_____

Employer: _____ Position/Occupation: _____

Parent/Guardian's Name: _____ Email: _____

Address: _____

Home #:_____ Cell#: _____ Work #:_____

Employer: _____ Position/Occupation: _____

In case of emergency, illness or injury, if the parent/s or guardian/s cannot be reached, the following persons may be contacted and sign my child in/out because of said emergency. The following persons (with valid I.D, and 18 or older) may pick up my child with written or verbal notification. I agree to provide notification in advance. (Be aware that children cannot leave without parent notification). Additional persons may be added to an emergency contact addendum sheet with full information.

EMERGENCY CONTACTS

1. Name: _____ Relation: _____

Address: _____ Home#: _____ Cell#: _____

2. Name: _____ Relation: _____

Address: _____ Home#: _____ Cell#: _____

3. Name: _____ Relation: _____

Address: _____ Home#: _____ Cell#: _____

In case of a natural disaster, local telephone lines may be out of commission. The following out-of-state person may be contacted in order to coordinate the well-being of my child.

1. Name: _____ Relation: _____

Address: _____ Home#: _____ Cell#: _____

CONSENT FOR EMERGENCY TREATMENT

Health Care Provider Information

Child's Name: _____

A. Physician's Name: _____

B. Medical Center or Clinic (Please Initial Your Provide Information)

1. Virginia Mason
380 Winslow Way E.
Bainbridge Island
206.842.5632

2. Group Health Cooperative
19379 7th Ave NE.
Poulsbo
1.800.719.9911

3. Bainbridge Pediatrics
1298 Grow Ave NW
Bainbridge Island
206.780.5437

4. The Doctor's Clinic
945 Hildebrand Ln.
Bainbridge Island
206.855.7700

Other/Name: _____
Address: _____
Phone#: _____

Dentist's Name: _____Phone#: _____

Address: _____

C. Medical Insurance: _____ Ins. #: _____

D. Dental Insurance: _____ Ins. #: _____

E. Date of last Tetanus (DTP) Immunization: _____

F. Allergies & Expected Symptoms: _____

_____

_____

G. Other Medical Information: _____

_____

_____

- I will notify BICCC of any medication my child is taking, prescription or otherwise.
- I grant permission for my child to receive first aid treatment by a qualified Bainbridge Island Child Care Centers staff member. In the event of an emergency beyond the capability of staff members, I grant permission for my child to be medically treated by Emergency Medical Technicians/Paramedics or transported to an emergency center for treatment.
- In the event that I cannot be contacted, I further consent to the medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed health care provider/emergency treatment center when deemed immediately necessary or advisable by the health care provider/emergency medical technician to safeguard my child's health.

Parent/Guardian Signature: _____ Date: _____