

# ST. LUKE PRESCHOOL & EARLY CHILDHOOD CENTER

## 2025-2026 EMERGENCY CONTACT FORM

**PLEASE LIST THE CLASS, DAYS & HOURS YOUR CHILD WILL BE ATTENDING**

**Class:** \_\_\_\_\_ **Days:** \_\_\_\_\_ **Hours:** \_\_\_\_\_

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mom's Name: \_\_\_\_\_ Dad's Name: \_\_\_\_\_

Mom's Cell # \_\_\_\_\_ Dad's Cell # \_\_\_\_\_

Mom's Work # \_\_\_\_\_ Dad's Work # \_\_\_\_\_

Mom's Email: \_\_\_\_\_ Dad's Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Occupation: \_\_\_\_\_

Child's Source of Medical Care/Primary Care Physician's Name:	Phone # _____
Child's Dentist's Name:	Phone # _____
Name of Medical Facility/Hospital:	Phone # _____

In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on this form) necessary for the proper health and well-being of my child.  
 \_\_\_\_\_ Yes \_\_\_\_\_ No

Please indicate who we can contact in case of an emergency and/or who is authorized to pick up your child when you are unable. **(Please, do not list a parent, you are the first we will call).**

Check either pick-up, emergency or both

Name	Contact Number(s)	Relationship to child	Pick-Up	Emergency
1				
2				
3				
4				

## Additional Emergency Contacts (optional)

Name	Contact Number(s)	Relationship to child	Pick-Up	Emergency
5				
6				
7				
8				
9				
10				
11				
12				

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Rooted in Faith, Abounding in Love.  
-Ephesians 3:17



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