ST. LUKE PRESCHOOL & EARLY CHILDHOOD CENTER

2026-2027 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. **(<u>Please, do not list a parent, you are the first we will call</u>).**

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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