Evergreen School

EMERGENCY INFORMATION

OFFICE USE ONLY

Child's Name (Last, First)

SCHOOL YEAR TEACHER

PROGRAM E-Bird E-Day

Child's Name (Last, First)

Birthdate Home Phone

Child's Home Address (Street, City, State, Zip)

Mother's Name (Last, First) Cell. Phone

Mother's Employer E-mail

Business Address (Street, City, State,Zip)

Business Telephone Fax Hrs. of Work Days off

Father's Name (Last, First) Cell. Phone

Father's Employer E-mail

Business Address (Street, City, State, Zip)

Business Telephone Fax Hrs. of Work Days off

Name of person/s authorized to pick up child daily (Including Parents).

Name Relationship Phone

Name Relationship Phone

Name Relationship Phone

In the event I/we cannot be reached, the following may be contacted to pick up my child (list 3).

Name Relationship Phone

Name Relationship Phone

Name Relationship Phone

I authorize Evergreen School to seek medical treatment for my child until I can be reached.

- ☐ He/she has no known allergies.
- ☐ He/she is allergic to ____________________
- ☐ Special medical problem____________________

Doctor Address Phone

Dentist Address Phone

I give permission for emergency treatment in my absence and will accept responsibility for any fees incurred.

Signature Date