



PARENT INFORMATION, EMERGENCY INSTRUCTIONS & MEDICAL RELEASE

| | | |
|---------------------------------------|-------------------------------|---|
| CHILD'S NAME: _____ | BIRTHDATE: _____ | RELIGION: _____ |
| PARENT / LEGAL GUARDIAN'S NAME: _____ | RACE/ETHNICITY: _____ | SELECT ONE: <input type="checkbox"/> NYCHA <input type="checkbox"/> RENT <input type="checkbox"/> OWN |
| ST. ADDRESS: _____ | HOUSEHOLD INCOME: _____ \$ | PREFERRED LANGUAGE: _____ |
| BORO: _____ ZIP: _____ | Classroom Assignment: _____ | |
| TEL. #: _____ | Teachers: _____ | |

IN AN EMERGENCY

MONDAY THROUGH FRIDAY, DURING WORKING HOURS
DIRECTOR / COORDINATOR: **IVONNE A. LOPEZ** TEL. NO. **347-296-4980**

| | |
|---|---|
| IF A CHILD REQUIRES EMERGENCY MEDICAL CARE | Type of Health Insurance: Check One <input type="checkbox"/> Medicaid <input type="checkbox"/> Employer Health Insurance <input type="checkbox"/> Other |
| CALL THE CHILD'S FAMILY DOCTOR: DOCTOR'S NAME _____ ADDRESS _____ TEL. NO. _____ | IF DOCTOR NOT AVAILABLE, TAKE CHILD TO THE NEAREST CITY HOSPITAL EMERGENCY CLINIC AT: _____ CLINIC NAME _____ ADDRESS _____ TEL. NO. _____ |

HEALTH INSURANCE PLAN _____ I.D. # _____

KNOWN MEDICAL PROBLEMS (allergies, diseases, etc.): _____

RELIGIOUS RESTRICTIONS: _____

PARENT'S AND RELATIVES' ADDRESSES AND TELEPHONE NUMBERS

| | | |
|-----------------------------|-----------------------------|----------------|
| MOTHER'S NAME : _____ | FATHER'S NAME: _____ | TEL. # : _____ |
| MOTHER'S WORK ADDRESS _____ | FATHER'S WORK ADDRESS _____ | |
| WORK TEL. #: _____ | WORK TEL. #: _____ | |
| RELATIVE/FRIEND NAME: _____ | RELATIVE/FRIEND NAME: _____ | |
| ADDRESS _____ | ADDRESS _____ | |
| TEL. # _____ | TEL. # _____ | |
| RELATIONSHIP _____ | RELATIONSHIP _____ | |

MEDICAL RELEASE

I hereby authorize (Name of Center) the **Brooklyn Community Services Atlantic Avenue Early Learning Center**, in the event of an emergency, to obtain whatever emergency medical treatment deemed necessary by appropriate medical authorities for my son/daughter _____.

Signature of Parent/Guardian _____ Date _____

APPROVED ESCORTS

NAME _____
RELATIONSHIP: _____
TEL. # _____

NAME _____
RELATIONSHIP: _____
TEL. # _____

APPROVED ESCORTS

NAME _____
RELATIONSHIP: _____
TEL. # _____

NAME _____
RELATIONSHIP: _____
TEL. # _____

APPROVED ESCORTS

NAME _____
RELATIONSHIP: _____
TEL. # _____

NAME _____
RELATIONSHIP: _____
TEL. # _____

APPROVED ESCORTS

NAME _____
RELATIONSHIP: _____
TEL. # _____

NAME _____
RELATIONSHIP: _____
TEL. # _____

APPROVED ESCORTS

NAME _____
RELATIONSHIP: _____
TEL. # _____

NAME _____
RELATIONSHIP: _____
TEL. # _____

APPROVED ESCORTS

NAME _____
RELATIONSHIP: _____
TEL. # _____

NAME _____
RELATIONSHIP: _____
TEL. # _____

APPROVED ESCORTS

NAME _____
RELATIONSHIP: _____
TEL. # _____

NAME _____
RELATIONSHIP: _____
TEL. # _____

APPROVED ESCORTS

NAME _____
RELATIONSHIP: _____
TEL. # _____

NAME _____
RELATIONSHIP: _____
TEL. # _____