MAYFLOWER
EARLY CHILDHOOD CENTER
MONTESSORI LEARNING ENVIRONMENTS

Date: _____

MECC Emergency Information

Child Information

Last Name	First Name	Calling Name	Date of Birth
Height	Weight	Hair Color	Eye Color
Allergies	Diet Restrictions	Food Sensitivities	Birthmark/Distinguishing Marks
Medication	Medication Expiration	Additional Information (attach if necessary)	

Medical Information

Pediatrician	Street Address/City/State	Phone Number
Health Insurance Provider	ID Number	Account Number

Dental Information

It is a DHS requirement we have the following information regarding your child on record. Our MN Nurse Consultant states that in lieu of an established pediatric dentist for your child, and no other dental relationship, you may use your personal dentist.

Dentist	Street Address/City/State	Phone Number
Pediatrician	Street Address/City/State	Phone Number
Health Insurance Provider	ID Number	Account Number

Parent/Guardian Information

Please provide primary contact information first.

Last Name	First Name	Street Address/City/State/Zip
Phone number	Secondary Phone Number	Email Address
Last Name	First Name	Street Address/City/State/Zip
Primary Phone Number	Secondary Phone Number	Email Address

Authorized Guardians

In case of an emergency and we're unable to contact parents, the following two persons may be contacted:

Last Name	First Name	Street Address/City/State
Primary Phone number	Secondary Phone Number	Email Address
Last Name	First Name	Street Address/City/State
Primary Phone number	Secondary Phone Number	Email Address

Additional Authorized Guardians

Last Name	First Name	Street Address/City/State
Primary Phone number	Secondary Phone Number	Email Address
Last Name	First Name	Street Address/City/State
Primary Phone Number	Secondary Phone Number	Email Address
Last Name	First Name	Street Address/City/State
Primary Phone number	Secondary Phone Number	Email Address
Last Name	First Name	Street Address/City/State
Primary Phone Number	Secondary Phone Number	Email Address

I understand that in some emergency situations the center may need to contact the emergency medical service (911) before the parent or guardian, child's physician, and/or other adults acting on the parents' behalf. In the event of a medical emergency, I understand that my child will be transported to the nearest hospital if the local emergency unit determines this is necessary for treatment.

I hereby grant permission to the staff of Mayflower Early Childhood Center to take whatever emergency measures are judged necessary for the care and protection of my child above named.

Parent Signature Date

_____

Parent Signature Date

_____