NORTHMINSTER COMMUNITY PRESCHOOL
1660 Kessler Boulevard East Drive
Indianapolis, Indiana 46220
317-251-9489 EXT 21

EMERGENCY MEDICAL INFORMATION

Child's Name _____
Home Address _____
Phone _____ School Year _____2026-2027
Date of Birth _____ Sex _____ Class _____

PARENT	PARENT
Name _____	_____
Work Place _____	_____
Phone _____	_____
E-mail _____	_____

If an emergency situation should occur concerning your child, we would immediately try to contact one or both parents. If neither parent can be contacted, we are to notify:

	NAME	PHONE	RELATIONSHIP
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Is your child taking any regular medication?_____If so,describe_____
Does your child have any allergies?_____If so, describe_____
How are allergies manifested? _____
Does your child have any dietary restrictions? _____ If so, describe_____

THIS SECTION MUST BE COMPLETELY FILLED OUT.

Name of Child's Doctor _____ Phone _____
Address _____
Name of Child's Dentist _____ Phone _____
Address _____
Hospital Preference _____
Medical Insurance Company _____
Policy/Group Number _____ Effective Date of Policy _____

EMERGENCY TREATMENT

In the event of an illness or accident which requires immediate medical treatment at a time when a parent cannot be located, I give permission for the Director of the above programs, or other school personnel designated by the Director, to authorize such treatment. I will not hold the school or medical personnel responsible. This is done with the understanding that every attempt will have been made to contact the parents, the child's physician, and other persons listed for emergency contact.

Signed _____ Date _____
Parent or Legal Guardian