

PARKVIEW COOPERATIVE PRE-SCHOOL



4550 Central Avenue
Indianapolis, Indiana 46205
317-921-7000

Emergency Information Form

Child's Class: _____

Child's Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

Address: _____

Mother's Name: _____ Day Phone: _____

Father's Name: _____ Day Phone: _____

Non-Parent Guardian: _____ Day Phone: _____

Emergency Contacts (not in the same household)

Contact 1:

Contact 2:

Name: _____

Name: _____

Relationship to child: _____

Relationship to child: _____

Day Phone: _____

Day Phone: _____

Physician

Child's Physician: _____ Phone: _____

Hospital Preference: _____

Additional Information

Does your child have any known communicable disease, chronic illness (asthma, seizure disorder, visual or hearing problem, etc)? Please describe (use back of form if necessary).

Has your child ever had any serious medical illness (febrile seizures, meningitis, respiratory problems, etc.)? If yes, please describe (use back of form if necessary).