

Easton Community Center

Playtots Preschool DCCC.16494

Emergency Contacts & Authorization for Pick-up

The names of at least one or two individuals, in addition to parents, who are authorized to pick up your child, must be on file with the program. If anyone else will be picking up your child, it is imperative that you notify the ECC. The ECC staff shall not release a child to anyone who is not authorized in writing for pick-up.

Child's Name: Parents/		D.O.B.	
Guardians Name: Cell			
Phone:		Home Phone:	
E-mail:			
Mother's Name:		Employer	
Father's Name:		Employer	
Employer Address:			Work Phone:
Employer Address:			Work Phone:

Password for Unusual Pickup Authorization

This password should be kept confidential. Only the parent and the ECC staff will know it. The password is used as a means of positively identifying a parent if they call the center to authorize an unusual pick-up. This password may also be used for the curbside sign-out. The pick-up person does not need to know the password. They will need to show a photo ID.

Check here if a court order exists limiting who may pick up your child/children from childcare, please bring in a copy of the court order, and a picture if available. Otherwise, we will assume that either parent can pick up your child or children.

Emergency Contacts & Authorized For Pick-Up (Other than parents)

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Doctor Information

Name	Phone
Address	Town
Preferred Hospital	Zip

Signature (Parent or Legal Guardian) _____ Date

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

In the event of an emergency requiring a physician's care, do you wish us to call your family physician?

Yes No (If yes, please provide the following.)

I (we), _____ and _____, do hereby state that I am (we are) parent(s) or legal guardian(s) of _____, who resides with me. I (we), _____ authorize for emergency purposes only, a designated employee of the Easton Community Center to transport the above minor by ambulance, and consent to any necessary examination, anesthetic, medical advice, and/or medical treatment from a physician or surgeon licensed to practice medicine in the State of Connecticut.

Allergies to drugs or foods: _____

Please list any special medications or pertinent information: _____