Peralta Community College District

Children's Centers

Campus: ☐ *Laney* ☐ *Merritt*

Emergency Contact and Medical Information

Child's Name: ___________________________________ ***Date of Birth:*** ____________________ ***Sex: M*** ☐ **F** ☐

Primary Parent's/ Guardian's Name:

____

_____________________ _______________________

Home Phone Number **Work Phone Number**

____

Cell Phone Number

____

Address

____

City **State** **Zip Code**

____

Email Address

Secondary Parent's/ Guardian's Name:

____

_____________________ _______________________

Home Phone Number **Work Phone Number**

____

Cell Phone Number

____

Address

____

City **State** **Zip Code**

____

Email Address

ADDITIONAL PERSONS TO CONTACT IN AN EMERGENCY AND/OR ADDITIONAL AUTHORIZED PERSONS TO TAKE CHILD FROM THE FACILITY

(1) Emergency Contact:

____

____

Home Phone **Work Phone**

____

Cell Phone

____

Address

____

City **State** **Zip Code**

(2) Emergency Contact:

____

____

Home Phone **Work Phone**

____

Cell Phone

____

Address

____

City **State** **Zip Code**

(3) Emergency Contact:

____

____

Home Phone **Work Phone**

____

Cell Phone

____

Address

____

City **State** **Zip Code**

(4) Emergency Contact:

____

____

Home Phone **Work Phone**

____

Cell Phone

____

Address

____

City **State** **Zip Code**

MEDICAL INFORMATION

____
Hospital/Clinic Preference

____ ______________________________________
Physician's Name Phone Number

____ ______________________________________
Dentist's Name Phone Number

____
Medical Number

CAMPUS WALKS CONSENT

[give permission for my child to participate in campus walks as part of the Children's Center Program.

_______________________________________ ____
Parent's/Guardian's Signature Date

CONSENT FOR EMERGENCY MEDICAL TREATMENT
Child Care Centers or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO Peralta Community College District Children's Centers TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.), OSTEOPATH (0.0.) OR DENTIST (D.D.S.) FOR:

____
(Child's Name)

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

Child has the following Medication Allergies/Medical Conditions/Allergies:

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____
Parent's or Authorized Representative's Signature **Date**