Sunny Faces Day Care, 30 Harefield Drive, Etobicoke ON, M9W 4C9 **(416 744 0778)**

EMERGENCY FORM

CHILD: _____ _____ _____
Surname **Given Names** **Nickname**

Date of Birth: (DD/MM/YY) _____ Age _____ Gender: Male _____ Female _____

Address _____City:_____ Postal Code: _____
House Number/Street Name

Home Phone # (_____) _____- _____ Cell Phone # (_____) _____- _____

PARENT #1: Name _____ Same address above: YES _____ NO_____

Home Address _____City:_____Postal Code _____
Street number

Home Phone # (_____) _____- _____ Cell (_____) _____- _____

Work Phone # (_____) _____- _____ Cell (_____) _____- _____

Email Address _____

PARENT/CAREGIVER #2: Name _____ Same address above: YES _____ NO_____

Home Address _____City:_____Postal Code _____
Street number

Home Phone # (_____) _____- _____ Cell (_____) _____- _____

Work Phone # (_____) _____- _____ Cell (_____) _____- _____

Email Address _____

Please give the names and telephone numbers of friends or relatives who would assume responsibility for your child in the event of an emergency or who are authorized to pick up your child (including spouses) in the event that we are unable to contact you.

Emergency #1 Name _____ _____ _____
First **Last** **Relationship**
Telephone Numbers: Home (_____) _____- _____ Cell (_____) _____- _____ Business (_____) _____- _____

Emergency #2 Name _____ _____ _____
First **Last** **Relationship**
Telephone Numbers: Home (_____) _____- _____ Cell (_____) _____- _____ Business (_____) _____- _____

Emergency #3 Name _____ _____ _____
First **Last** **Relationship**
Telephone Numbers: Home (_____) _____- _____ Cell (_____) _____- _____ Business (_____) _____- _____

Medical Information

CHILD'S NAME _____ Date of Birth _____
DD/MM/YY

Please check the appropriate boxes

Reason	○ **Medical** ○ **Allergy**	○ **Sensitivities**
Level of Concern	○ **Life-Threatening**	○ **Non-Life-Threatening**
Doctor's Note on File	○ **Yes**	○ **No**

Foods and other allergies, sensitivities (medical) – please be detailed

Plan of action in case of accidental ingestion of this restricted food and/or when described symptoms are observed (please be as detailed as possible).

Contact this parent first:	**Phone #:**

Doctor's Information

Name _____ _____ Phone # _____
First **Last**

Address _____ Postal Code _____

DATE: _____ SUPERVISOR SIGNATURE: _____