Little Sprouts Children's Center
CHILD EMERGENCY & PICK UP INFORMATION

Child Name:_____
Parent/ Guardian #1 Names and Phone:_____
Parent/Guardian #2 Name and Phone:_____
DOB:_____
Home Address:_____
Emergency Contact #1 Name and Phone:_____
Emergency Contact #2 Name and Phone:_____
Hospital/Clinic Name and Address_____
Provider Name and Phone: _____
Dentist Name and Phone:_____
Insurance Information:_____
Allergies:_____

Has your child experienced any of the following (please circle)
Asthma/Wheezing **Heart Condition** **Kidney/Bladder Problems**
Strep Throat/Scarlet Fever **Seizures** **Mumps/Measles**
Chicken Pox **Frequent Bloody Noses** **Gastrointestinal Problems** **Frequent Headaches** **Frequent Ear Infections**
If so, please elaborate to help us care for your child:

_____

_____

_____

I authorize LSCC Staff to seek any and all emergency medical and dental services for my child in my absence, with no liability to pay for said service. I understand that any medical services sought for my child will be only after reasonable attempts to contact parents were made.

People picking up your child on a regular basis:

_____

_____

People allowed pick up with prior notice and ID:

_____

_____