MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

CACFP Enrollment:Yes:☐ No:☐

Meals your child will receive while in care:

BK___ LN___SU___ AM Snk___ PM Snk___ Evng Snk___

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

(1) Complete all items on this side of the form. Sign and date where indicated.

(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name Taragin (Last) Henry (First) Birth Date 9/20/2015

Enrollment Date 2/9/2021 Hours & Days of Expected Attendance 8 am to 4 pm, M-F

Child's Home Address 11743 Lovejoy St (Street/Apt. #) Silver Spring (City) MD (State) 20902 (Zip Code)

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
Charles Taragin	Father	Place of Employment: Federal Trade Commiss W: 202-227-1554	C: 773-771-0004	H:
Hilary Bierman	Mother	Place of Employment: University of Maryland C W:	C: 734-276-6812	H:

Name of Person Authorized to Pick up Child *(daily)* _____ (Last) (First) (Relationship to Child)

Address _____ (Street/Apt. #) (City) (State) (Zip Code)

Any Changes/Additional Information_____

_____

ANNUAL UPDATES _____ *(Initials/Date)* _____ *(Initials/Date)* _____ *(Initials/Date)* _____ *(Initials/Date)*

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ (Last) (First) Telephone (H) _____ (W) _____

   Address _____ (Street/Apt. #) (City) (State) (Zip Code)

2. Name _____ (Last) (First) Telephone (H) _____ (W) _____

   Address _____ (Street/Apt. #) (City) (State) (Zip Code)

3. Name _____ (Last) (First) Telephone (H) _____ (W) _____

   Address _____ (Street/Apt. #) (City) (State) (Zip Code)

Child's Physician or Source of Health Care _____ Telephone _____

Address _____ (Street/Apt. #) (City) (State) (Zip Code)

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

1. Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
2. If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: ______________________________ Date of Birth: ______________

Medical Condition(s): ____

____

Medications currently being taken by your child: ______________________________

____

Date of your child's last tetanus shot: ______________________________

Allergies/Reactions: ____

____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: ______________________________

____

(2) If signs/symptoms appear, do this: ______________________________

(3) To prevent incidents: ______________________________

____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: ______________________

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____

COMMENTS: ____

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Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

______________________________ Name of Health Practitioner

______________________________ Date

______________________________ Signature of Health Practitioner

(_____)______________________ Telephone Number