# KEANE CARE EMERGENCY FORM

(Please Print)______________________________

Child's Name Last First Age Grade

______________________________

Address City Zip Code

______________________________

Mother's Name Daytime Phone

______________________________

Home Phone Cell Phone

______________________________

Father's Name Daytime Phone

______________________________

Home Phone Cell Phone

PLEASE GLUE CHILD'S PHOTO HERE.

In the event of apparent serious illness, accident, or emergency, when I cannot be reached, I wish one of the following to be notified. They are authorized to act in my absence.

______________________________

Name Relationship Phone

______________________________

Name Relationship Phone

______________________________

Birth date

In the event of apparent serious illness, accident, or emergency when I or one of the above cannot be reached, I authorize the Keane Care supervisory staff to contact 911 or my child's doctor or dentist.

______________________________

Parent's signature

______________________________

Child's Doctor Phone Dentist Phone

______________________________

PERSONS AUTHORIZED TO TAKE CHILD FROM THE KEANE CARE CENTER:

______________________________ ______________________________

Name Phone Name Phone

______________________________ ______________________________

Name Phone Name Phone

______________________________ ______________________________

Name Phone Name Phone

If parents are divorced or separated, please complete the following for the parent NOT in the home.

______________________________

Parent's name Address Phone

May he/she take child from the center?
If NO please attach custody agreement and/or restraining order,

______________________________

Parent's Signature