MERCY HEIGHTS CATHOLIC NURSERY & KINDERGARTEN

211 San Vitores St., Perezville-Tamuning, GU · Tel: (671) 646-1185 · Fax: (671) 649-1822 email:mhcnk211@gmail.com

CHILD EMERGENCY AUTHORIZATION CARD

Name: ____ Date of Birth:_________ Male:_____ Female:____

EMERGENCY CONTACTS

Father's Name:_______________________________________ Home Phone:_________ Cellphone: ____________

Home Address:____ E-mail Address:____________________________

Place of Work:____ Work Phone:___________________

Mother's Name:_______________________________________ Home Phone:_________ Cellphone:____________

Home Address:____ E-mail Address:____________________________

Place of Work:____ Work Phone:___________________

Please provide at least three (**other than the ones listed above**) emergency contacts & authorized adults to **pick up child**

1. Name:____ Relation to the child:____________________________

Home Phone:____________________ Work Phone:___________________ Cellphone:___________________

PhysicalAddress:____

2. Name:____ Relation to the child:____________________________

Home Phone:____________________ Work Phone:___________________ Cellphone:___________________

PhysicalAddress:____

3. Name:____ Relation to the child:____________________________

Home Phone:____________________ Work Phone:___________________ Cellphone:___________________

Physical Address:____

Please update for changes in contact information

IF MEDICAL CARE IS NECESSARY, CONTACT:

Name of Physician:________________________________ Clinic:___________________________ Phone:______________________

Name of Dentist:__________________________________ Clinic:___________________________ Phone:______________________

Please check condition applicable to your child that may require attention while at school

___ Hearing impairment requiring preferential seating or complete hearing loss

___Diabetes

___ Vision impairment requiring preferential seating or complete vision loss

___ Seizure (epilepsy, etc.)

___Malignancy (leukemia, sarcoma, Hodgkin's disease, etc.)

___ Digestive Disorder (ulcers, colitis, etc.)

___ Neurological Problem (cerebral palsy, hydrocephalus, etc.)

___ Heart Condition that limits activity

___ Orthopedic Problem which limits physical activity

___ Severe Reaction to insect stings/bites

___ Urinary tract disorder (nephritis, absence of kidney/bladder)

___ Respiratory Problem (asthma, cystic fibrosis, etc.)

___ Blood disease (sickle cell anemia, plastic anemia, malaria, hemophilia, etc.

___ other (specify)____

Additional helpful information in the care or guidance of your child

1. Eating and Sleeping Habits:____

2. Toileting Habits:____

3. Fears and Preferences:____

Additional List: Complete full name of all persons authorized to take the child from the MHCNK (Child will not be released to anybody not listed below.

1. ____Relation to the Child:_________________________________

2. ____Relation to the Child:_________________________________

3. ____Relation to the Child:_________________________________

___ I authorize Mercy Heights Catholic Nursery & Kindergarten staff to procure medical, hospital, or dental care for my child in the event of injury or illness, if I cannot be reached. I understand and accept all expenses incurred.

___ I do not authorize the staff of Mercy Heights Catholic Nursery & Kindergarten to oversee any medical treatment in my absence.

Insurance Carrier:____________________________ __Number:_________________________ SSN:___________________________

Signature of Parent/Guardian:_________________________ Date:______________ _______Witness:___________________