

Emergency Contact Information 2015/16

Full name of child:

Class:

Date of birth:

Position in family (eg, eldest of three is 1/3):

Name, address and relationship of the adult(s) with whom the child is now living:

Name(s): (Mr) (,Mrs)(,Ms) (Miss)(Dr) (Other)

Relationship(s):

Address:

Post Code:

Home telephone number: Dialling code ()

Mobile telephone number:

Mobile number for text messaging:

Work telephone number:

E-mail address:

Have you changed address within the last year . YES/NO

In case we were unable to contact someone at home, please list any alternatives – workplace details, relatives, friends, etc. To avoid any embarrassment or confusion please let friends or neighbours know that you have given us their names.

1 Name Relationship Address Tel numbers Hours of work	2 Name Relationship Address Tel numbers Hours of work
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Travel Arrangements : Walk, Car, Bus, Taxi, Car Share, Other - please indicate

Services Family YES/NO

Does your child have any medical needs e.g. asthma, allergies etc YES/NO

Does your child have any disabilities or impairments e.g. hearing/eyesight etc YES/NO

Has your child undergone any operation, serious illness or accident? YES/NO

If yes to any of the above, please fill in a separate Medical Information Sheet.

If I/we cannot be contacted in an emergency, I/we give permission for my/our child to have any dental or medical treatment that may be necessary. Therefore, it is imperative that you return this form as soon as possible.

Doctor's Name and clinic:

Date of last tetanus:

Signed

Relationship

Date