NIHONMACHI LITTLE FRIENDS **Emergency Information**

Parent's Name: _____

Home Address: _____

Home Phone: _____

Email Address: _____

Child Name: _____

Date of Birth: _____

	Work Address	Phone	Cell Phone
Parent/guardian:			
Parent/guardian:			

Physician to be called in Emergency: _____

Address: _____ Medi-cal#: _____

Phone: _____ Medical Record#: _____

Allergies or medical limitation: _____

Other authorized persons who can pick up your child: *(please list at least 2 and if more, use the backside of this card)*

Name	Relationship	Phone	Cell Phone

In case of an accident of emergency, I authorized a staff member of Nihonmachi Little Friends to take my child to the above-named physician or to the nearest emergency hospital for such emergency treatment & measures as are deemed necessary for the safety and protection of my child.

Signature of parent or guardian: _____ Date: _____