



Emergency Release Form/Application for Enrollment

Child's Name:	
Parents' Names:	
Parents' Address:	
Home Phone:	E-mail:
Business Phone (Mother):	Cell:
Business Phone (Father):	Cell:
Insurance Company:	Policy Number:
Name of Child's Dentist:	Phone:
Name of Child's Physician:	Phone:

In the event of sickness or accident if the parent, guardian, if your physician or your dentist cannot be reached, may we use our physician or dentist? And/or the nearest hospital _____

- ANY SPECIAL PROBLEMS OR ALLERGIES? _____
- ALLERGIC TO ANY MEDICATION(S) _____
- ALLERGIC TO ANY FOODS _____
- SYMPTOMS OF THIS ALLERGY _____
- ACTION TO BE TAKEN _____

EMERGENCY CONTACT PERSONS (other than parents):

Name:	Home Phone:
Work Phone:	Cell:
Name:	Home Phone:
Work Phone:	Cell:
Name:	Home Phone:
Work Phone:	Cell:

The school has my permission in an emergency, when I or my dentist or physician cannot be contacted to take my child to the nearest dental office, or to the emergency room of the nearest hospital and the dentist or hospital staff has my permission and authority to give emergency care when a physician deems it necessary for the wellbeing of the child.

 Parent or Guardian

 Signature of Director

Date: _____

Police	911	3137 Research Drive, State College, PA 16801
Ambulance	911	400 West Beaver Avenue, State College, PA 16801
Fire	911	400 West Beaver Avenue, State College, PA 16801
Hospital	234-6110	1800 East Park Avenue, State College, PA 16801