

**EMERGENCY/RELEASE INFORMATION**

School for Little Children    Bellaire United Methodist Church  
4417 Bellaire Blvd. • Bellaire, TX 77401 • 713-666-1111 • Fax: 713-666-2118

**CHILD'S NAME** \_\_\_\_\_ **EMERGENCY PHONE** \_\_\_\_\_

**Parent 1 Name** \_\_\_\_\_

Daytime address with zip code \_\_\_\_\_

Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

**Parent 2 Name** \_\_\_\_\_

Daytime address with zip code \_\_\_\_\_

Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

**Non-parent Emergency Contact Name** \_\_\_\_\_

Relationship to child \_\_\_\_\_

Daytime address with zip code \_\_\_\_\_

Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

The above emergency contact has my permission to pick up my child/children. [redacted] (parent initial)

List **additional persons** to whom School for Little Children may release your child. (caregivers, carpool drivers, and anyone else who may pick up your child) Please notify the office when you need to drop or add names during the school year.

My child, \_\_\_\_\_, may be released to the following persons:

<u>NAME</u>	<u>RELATION TO CHILD</u>	<u>PHONE NUMBER</u>
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Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Complete address with zip \_\_\_\_\_

Hospital preference and location (if possible) \_\_\_\_\_

**In case of accident or illness and in case we, his/her parents or guardians, are not available, I/we authorize School for Little Children personnel to administer or secure any and all emergency medical treatment to the child named. I give consent for my child to be transported and supervised by School for Little Children personnel in case of emergency. [redacted] (initial)**

\_\_\_\_\_  
**Parent/Guardian signature**

Health Insurance Carrier: \_\_\_\_\_ Phone: \_\_\_\_\_ Policy Number: \_\_\_\_\_

