# THE ROSLYN-TRINITY COOPERATIVE DAY SCHOOL

1579 Northern Boulevard
Roslyn, New York 11576
(516) 621-3380
Fax (516) 621-3258
www.roslyntrinityco-op.org

## EMERGENCY CONTACT FORM

**Please clearly print all information on this form.**

**Child's Name** ______________________________________ ☐ Male ☐ Female
First Name Last Name

Date of Birth ______/______/______ Home Phone ( ) ____________________

Address ________________________________________________________

________________________________________________________________

Email Address ______________________________

**In the event of an emergency, Roslyn Trinity Cooperative Day School will attempt to contact the parent(s).**

**Parent's Name** ______________________________

Home Phone ( ) ____________________ Hours/Days ____________________

Work Phone ( ) ____________________ Hours/Days ____________________

Cell Phone ( ) ____________________ Hours/Days ____________________

**Parent's Name** ______________________________

Home Phone ( ) ____________________ Hours/Days ____________________

Work Phone ( ) ____________________ Hours/Days ____________________

Cell Phone ( ) ____________________ Hours/Days ____________________

**The following people are allowed to pick up my child if I am unable to do so and will be contacted in the event of an emergency if I am unavailable.**

1. Name ______________________________ Phone ( ) ____________________

   Address ______________________________________________________

   Relationship to child ____________________

2. Name ______________________________ Phone ( ) ____________________

   Address ______________________________________________________

   Relationship to child ____________________

3. Name ______________________________ Phone ( ) ____________________

   Address ______________________________________________________

   Relationship to child ____________________

**(Continued on reverse)**

**Family Physician or Child's Pediatrician**

Name ______________________________________ Phone (        ) ______________________________

**Child's Dentist**

Name ______________________________________ Phone (        ) ______________________________

**Allergies--please list:**

**Allergies to medications** ____________________________________________________________

**All other allergies** _________________________________________________________________

Permission is hereby granted for the Roslyn-Trinity Cooperative Day School director and staff to have access to health information about my child and to seek emergency medical treatment for my child, ____________________________________________, in the event that I cannot be contacted immediately.

Parent's signature ____________________________________________ Date ____________________