

**Emergency Contact Pick-Up Information**  
*(Please Read Carefully)*

**EMERGENCY CONTACTS:** Please list individuals to whom your child may be released) other than yourself or spouse) in order that you wish them to be called to include all persons with whom you are car pooling with. Please verify with persons below that they maybe called in case of your child's illnesses or emergency in the event that the child has not been picked up within 30 minutes of the school day.

**NOTE: Your child will not be released unless a contact name, address and telephone numbers appear below.**

1. Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Relationship to child \_\_\_\_\_ Relationship to parents \_\_\_\_\_ other info \_\_\_\_\_

2. Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Relationship to child \_\_\_\_\_ Relationship to parents \_\_\_\_\_ other info \_\_\_\_\_

3. Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Relationship to child \_\_\_\_\_ Relationship to parents \_\_\_\_\_ other info \_\_\_\_\_

**MEDICAL INFORMATION**

Before any medication is dispensed to my child, I will provide a written authorization, which includes dates; name of child; name of medication; prescription number, if any; dosage; date and time of medication is to be given. Medicine will be in the original container with my child's name marked on it.

Are medications being taken on a regular basis?       Yes       No  
If yes, please describe: \_\_\_\_\_

Diagnosed behavior disorder or learning disability?       Yes       No  
If yes, diagnosed by: \_\_\_\_\_

\_\_\_\_\_  
Student's Physician: \_\_\_\_\_ Office Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

In the event that I cannot be reached, I give permission for this Student to be transported to Douglas County Hospital, and authorize the hospital to provide emergency medical or surgical treatment. I will assume full responsibility for all charges related to the above and release the serving hospital, Douglas County General, Majestic Learning Center, Inc., its Agents, Employees, Administrators and all liability claims and causes of actions arising in connection with the transportation and or treatment of the student named hereon.

My signature below indicates that I have read and understand the preceding information and I agree to abide by the policies and procedures set forth by Majestic Learning Center, Inc. I certify that the information I have provided on this emergency form is true and correct to the best of my knowledge. I also realize that it is my responsibility to keep the information on this form correct.

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*Parent or Legal Guardian Signature* *Date*

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*Facility Administrator/Person in Charge* *Date*