BEN SAMUELS
CHILDREN'S CENTER
MONTCLAIR STATE UNIVERSITY

EMERGENCY INFORMATION FORM

Child's Name: ____

Parent Name: ____

Home Phone: __________________ **Work Phone:** ____________________ **Cell:** ____________________

Email: ____

Parent Name: ____

Home Phone: __________________ **Work Phone:** ____________________ **Cell:** ____________________

Email: ____

If Parent is MSU student, we kindly ask that a copy of current class schedule be attached.

Name of person to contact if parents are unavailable:

Name: ____

Full Address: ____

Phone: ___________________________**Cell:**___________________________

Name of Physician: ____

Full Address: ____

Phone: ______________________________

In the event that I can not be reached, I give permission for my child to be taken to the hospital to receive emergency treatment.

____
(Signature of Parent/Guardian)

____
(Date)