

ARLINGTON HEIGHTS PARK DISTRICT EMERGENCY CONTACT FORM

**PRESCHOOL PROGRAM**

CHILD'S NAME \_\_\_\_\_ 2024-2025 PRESCHOOL YEAR

HOME ADDRESS \_\_\_\_\_

PARENT'S NAME \_\_\_\_\_ PARENT'S NAME \_\_\_\_\_

MAIN PHONE \_\_\_\_\_ MAIN PHONE \_\_\_\_\_

EMAIL \_\_\_\_\_ EMAIL \_\_\_\_\_

EMERGENCY CARE (Please list names of two adults other than the parents who could be contacted if needed)

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_

PHYSICIAN'S PHONE NUMBER \_\_\_\_\_

List any medical allergies, chronic illnesses, daily medication or other important condition information:

\_\_\_\_\_  
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