SUNSHINE SCHOOL **175 Kihapai Street, Kailua, Hawaii 96734**

EMERGENCY INFORMATION FORM

CHILD'S NAME_____BIRTH DATE_____TELEPHONE_____

ADDRESS_____

FATHER'S NAME_____DAY-TIME TELEPHONE_____

FATHER'S EMAIL ADDRESS _____

MOTHER'S NAME_____DAY-TIME TELEPHONE_____

MOTHER'S EMAIL ADDRESS _____

LEGAL GAURDIAN'S NAME_____TELEPHONE_____

LEGAL GAURDIAN'S ADDRESS_____

PERSONS WHO MAY PICK UP YOUR CHILD IF (S)HE BECOMES ILL. THESE PEOPLE WILL ACT AS YOUR CHILD'S EMERGENCY CONTACT

NAME_____RELATIONSHIP_____TELEPHONE_____

ADDRESS_____CELL_____

NAME_____RELATIONSHIP_____TELEPHONE_____

ADDRESS_____CELL_____

NAME_____RELATIONSHIP_____TELEPHONE_____

ADDRESS_____CELL_____

PERSONS WHO WILL BE ALLOWED TO PICK UP YOUR CHILD FROM SCHOOL. NO OTHERS WILL BE ALLOWED TO PICK UP YOUR CHILD WITHOUT SPECIAL PERMISSION FROM YOU.

NAME_____RELATIONSHIP_____TELEPHONE_____

ADDRESS_____CELL_____

NAME_____RELATIONSHIP_____TELEPHONE_____

ADDRESS_____CELL_____

NAME_____RELATIONSHIP_____TELEPHONE_____

ADDRESS_____CELL_____

DOES YOUR CHILD HAVE ANY DIETARY OR PHYSICAL RESTRICTIONS?

DESCRIBE_____ALLERGIES?_____

YOUR PERMISSION IS REQUIRED FOR SUNSHINE SCHOOL TO PROVIDE EMERGENCY MEDICAL HELP FOR YOUR CHILD. IN AN EXTREME EMERGENCY WE WILL GET IMMEDIATE MEDICAL HELP AT CASTLE MEDICAL CENTER, 640 ULUKAHIKI ST, KAILUA, 263-5500, AND WE WILL NOTIFY YOU THAT TREATMENT IS BEING PROVIDED.

PARENT/GAURDIAN SIGNATURE TO PERMIT THIS HEALTH SOURCE

SIGNATURE_____DATE_____

PLEASE PROVIDE US WITH THE NAME OF YOUR CHILD'S DOCTOR_____

ADDRESS_____TELEPHONE_____

WE WILL TRY TO CONTACT YOUR PREFERRED DOCTOR.

MEDICAL INSURANCE PLAN_____PLAN NO._____