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.______________________

May 2015