

**Tri-County Opportunities Council  
Head Start/Early Head Start Program  
EMERGENCY CARD**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Mother/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Hours: \_\_\_\_\_  
 Mother's Work Phone: \_\_\_\_\_  
 Father/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Hours: \_\_\_\_\_  
 Father's Work Phone: \_\_\_\_\_

*People, other than parents, to notify in case of emergency/authorization to release (must be 13 years or older/must be local):*

NAME	ADDRESS	RELATIONSHIP	PHONE

Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Dentist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Dual Enrollment: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Teacher: \_\_\_\_\_ Transportation Arrangements: \_\_\_\_\_  
 Medical Data/Special Needs \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Current Medication: \_\_\_\_\_  
 Medicaid # or Insurance #: \_\_\_\_\_

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