

**SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE
EARLY CHILDHOOD CENTER**

EMERGENCY FORM

YEAR:

(CHILD'S Last Name)

(CHILD'S First Name)

(Street Address)

(City)

(State)

(Zip Code)

Known Allergies _____

Quick Contact Info – "on call" parent/emergency contact

Name & Cell # (call 1st):

Email: _____

Name & Cell # (call 2nd):

Email: _____

Parent Information:

_____ **SIUE Student*** _____
(Name) (Daytime/Work Phone)

_____ (Business Name- if applicable) _____ (Location)

_____ **SIUE Student*** _____
(Name) (Daytime/Work Phone)

_____ (Business Name- if applicable) _____ (Location)

Local Emergency Contacts (other than person(s) listed above):

Can pick up?

Name: _____ Relationship: _____ Phone: _____ yes

Name: _____ Relationship: _____ Phone: _____ yes

Name: _____ Relationship: _____ Phone: _____ yes

_____ is the preferred doctor/clinic/hospital.

***SIUE Students & Faculty/Staff:** Please provide **BANNER ID #(s)** _____, _____, and your current semester class schedule(s) for the hours your child attends the Early Childhood Center.

My signature on this form authorizes Early Childhood Center Staff to secure emergency medical care for my/our child when I/we cannot be immediately reached at the time of emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement.

Fall 2025 - Parent/Guardian Signature Date

Spring 2026 - Parent/Guardian Signature (you will be asked to sign at the beginning of semester) Date

Summer 2026 - Parent/Guardian Signature Date

If needed: Parent/Guardian Signature (for updated Information only) Date

>>>> *Please update in the ECC office when/if changes occur* <<<<