DUBLIN
CALIFORNIA

City of Dublin

EMERGENCY INFORMATION FORM

Please complete ALL SECTIONS of this form.

A completed form must be on file before your child can be admitted into the City of Dublin's programs.

PERSONAL INFORMATION (one child per form, please)

Child's Name: _____ (_____) Age: _____ Birth date: _____/_____/_____
First Last Nickname

Mother's Name: _____ Cell: (_____)_____
First Last

Address: _____ Home phone: (_____)_____
Street

_____ Work phone: (_____)_____
City State Zip

Email Address: _____ Best number to call? ☐ cell ☐ home ☐ work

Father's Name: _____ Cell: (_____)_____
First Last

Address: _____ Home phone: (_____)_____
Street

_____ Work phone: (_____)_____
City State Zip

Email Address: _____ Best number to call? ☐ cell ☐ home ☐ work

Child's first Language: _____ **Does your child speak English?** _____ **Does your child understand English?** _____

Sibling's Name: _____ Age _____ Sibling's Name: _____ Age _____

Sibling's Name: _____ Age _____ Sibling's Name: _____ Age _____

MEDICAL INFORMATION

Child's Physician: _____ Phone: (_____)_____

Medical Insurance Carrier: _____ Insurance/Group Identification Number: _____

Allergies: (***Please indicate "None" if no allergies exist***)

_____

Please tell us if your child has any medical conditions; special dietary needs or restrictions; special needs; social, emotional, developmental, language, and/or behavior concerns (i.e. shyness, problems sharing, etc.); or family or other issues that may present themselves? (***Please indicate "None" if no conditions or issues exist***)**:**

_____

_____

Please tell us of your child's strengths and special interests

_____

_____

EMERGENCY CONTACTS AND PERSONS AUTHORIZED TO PICK UP CHILD, OTHER THAN PARENTS (must include at least one)

Name: _____ Relationship: _____ Phone: (_____)_____ Cell: (_____)_____

Name: _____ Relationship: _____ Phone: (_____)_____ Cell: (_____)_____

I verify the above information is true and correct.

_____ _____
Signature of Parent or Guardian *Date*