OPEN ARMS LUTHERAN CHILD DEVELOPMENT CENTER OF BUCKHEAD, INC.

EMERGENCY CONTACT INFORMATION & AUTHORIZATION

Please provide the following State required information regarding your child.
Please DO NOT leave any items blank.

Child's Full Name: _____ Nickname: _____

Age: _____ Date of Birth: _____ Sex: ❑ M ❑ F

Street: _____

City: _____ State: _____ Zip: _____

	Father	Mother	Legal Guardian / Step Parent *(Leave blank if not applicable)*
Name *(First & Last)*			
Work Phone #			
Cell Phone #			
E-Mail			

PERMISSION TO PICK-UP

Persons (other than parents/guardians) having permission to pick up your child must be 18 years of age or older:

Name *(First & Last)*	1.	2.	3.
Street			
City, State & Zip			
Home Phone #			
Work Phone #			
Cell Phone #			
Relationship to child			

NOTE: Individuals stated above must bring a driver's license in order to pick up your child(ren) at Open Arms. *Please notify us any time someone else will be picking up your child (see front desk).* ***If their name is not on our list and we have no other instructions in writing from you, we will not allow them to leave with your child.***

4000 ROSWELL ROAD NE • ATLANTA, GA 30342 • TEL: 404.256.1330 • FAX: 404.941.2298
WWW.OPENARMSBUCHEAD.ORG

IN CASE OF EMERGENCY WHERE PARENTS CANNOT BE REACHED, PLEASE CONTACT:

Required: Minimum of **TWO LOCAL** persons and one other person (even if out of state):

Name *(First & Last)*	1.	2.	3.
Street			
City, State & Zip			
Home Phone #			
Work Phone #			
Cell Phone #			
Relationship to child			

MEDICAL PROVIDER & INFORMATION

Name of Physician: _____ Phone #: _____

Street _____

City_____ State_____ Zip_____

Child's medical conditions (asthma, diabetes, drug allergies, etc.): _____

Current prescribed medication: _____

Child's Special Medical Needs and Conditions: _____

EMERGENCY MEDICAL AUTHORIZATION

In the event of an emergency involving my child, _____, and if Open Arms Buckhead is unable to contact me immediately, I hereby authorize Open Arms Buckhead to secure any needed medical emergency medical care and attention. I agree to keep the school informed of changes in telephone numbers, etc. where I can be reached. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child and to hold harmless and release Open Arms Lutheran Child Development Center, its owner, employees, representatives, or any other person(s) affiliated with the company from all liability. The School agrees to keep me informed of any incidents requiring professional medical attention involving my child.

The Medical Facility used by Open Arms Buckhead is:

Children's Healthcare of Atlanta at Scottish Rite
1001 Johnson Ferry Rd Ne, Atlanta, GA 30342
(404) 785-5252

Signature (Parent/Legal Guardian): _____ Date: _____