

# Family Emergency Information Form

**This form provides critical information in the case of an emergency.  
Please complete all portions and initial.**

Last Name: \_\_\_\_\_ Father: \_\_\_\_\_ Mother: \_\_\_\_\_

**List children's names, including last name if different than parents.**

Child: \_\_\_\_\_ Child: \_\_\_\_\_  
 Child: \_\_\_\_\_ Child: \_\_\_\_\_  
 Child: \_\_\_\_\_ Child: \_\_\_\_\_  
 Child: \_\_\_\_\_ Child: \_\_\_\_\_

**Emergency Contact's Name (offsite during classes)**  
 \_\_\_\_\_

**Emergency Contact's Phone Number**  
 \_\_\_\_\_

**Father's Work Phone Number**  
 \_\_\_\_\_

**Father's Cell Phone Number**  
 \_\_\_\_\_

**Family Home Phone**  
 \_\_\_\_\_

**Mother's Work Phone Number**  
 \_\_\_\_\_

**Mother's Cell Phone Number**  
 \_\_\_\_\_

**Doctor's Name**  
 \_\_\_\_\_

**Doctor's Phone Number**  
 \_\_\_\_\_

**Medical Considerations: Please check one box for each section below:  
 Medical Information is NOT retained after each semester.  
 Please list all medical considerations for each child.**

**In case of Emergency, will your child(ren) require special assistance during an evacuation due to a physical disability?**  Yes  No  
 If yes, list the child's name and explain their evacuation needs (such as wheel-chair assistance required).

Child's Name: \_\_\_\_\_ Evacuation Needs: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Evacuation Needs: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Evacuation Needs: \_\_\_\_\_

**Are there any allergies that need consideration for your child(ren)?**  Yes  No  
 If yes, list the child's name and indicate allergies, noting anything that may be life threatening.

Child's Name: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Is this condition life threatening?  Yes  No

Child's Name: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Is this condition life threatening?  Yes  No

Child's Name: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Is this condition life threatening?  Yes  No

**Does your child(ren) have any medical considerations that require attention or may hinder them from class participation?**  Yes  No  
 If yes, list the child's name below and explain any medical considerations, noting anything that may be life threatening.

Child's Name: \_\_\_\_\_ Medical Considerations: \_\_\_\_\_  
 Is this condition life threatening?  Yes  No

Child's Name: \_\_\_\_\_ Medical Considerations: \_\_\_\_\_  
 Is this condition life threatening?  Yes  No

\*Please contact the HCEC Administrator via email at [ECAdministrator@hche.org](mailto:ECAdministrator@hche.org) for approval of any accommodations needed for class participation.

<b>Parents Initial</b>	<b>Date</b>	<b>Best Onsite Cell Phone Number:</b> _____  <b>I understand it is the responsibility of the parent and <u>not</u> HCEC or New Life Church to attend to the medical conditions and/or needs of my children and that I am required to keep my cell phone available during class hours for emergency purposes.</b>
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