BEN SAMUELS
CHILDREN'S CENTER
MONTCLAIR STATE UNIVERSITY

EMERGENCY INFORMATION FORM

Child's Name: _____

Parent/Guardian Name: _____

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

Email: _____

Parent/Guardian Name: _____

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

Email: _____

If Parent is MSU student, we kindly ask that a copy of current class schedule be attached.

Name of person to contact if parents are unavailable:

Name: _____

Full Address: _____

Phone: _____ **Cell:** _____

Name of Physician: _____

Full Address: _____

Phone: _____

In the event that I can not be reached, I give permission for my child to be taken to the hospital to receive emergency treatment.

_____
(Signature of Parent/Guardian)

_____
(Date)

Mailing:
1 NORMAL AVENUE
MONTCLAIR, NJ 07043

Location:
80 CLOVE ROAD
LITTLE FALLS, NJ 07424

T 973 655 7177
F 973 665 5155