MARYLAND STATE DEPARTMENT OF EDUCATION - Office of Child Care

GACFP Enrollment: Yes:___No:__ Meals your child will receive while in care: BK__LN__SU__AM Snk__PM Snk__Evng Snk__

EMERGENCY FORM

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			Hours &	Days of Expected Atten	danne		
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Child's Home AddressStreet/Apt. #			Clty State Zip Cod				
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dress	Street/Apt.#		Clty	Sta	le	Zlp Code	
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INSTRUCTIONS TO PARENT/GUARDIAN:

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name;	Date of Birth:
Medical Condition(s):	
	•
•	,
EMERGENCY MEDICAL INSTRUCTIONS: (1) Signs/symptoms to look for:	
(2) If signs/symptoms appear, do this:	
(3) To prevent incidents:	
	,
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OTHER SPECIAL MEDICAL PROCEDURES THAT MAY	BE NEEDED:
•	
COMMENTS:	•
•	•
Note to Health Practitioner:	
If you have reviewed the above information, pleas	e complete the following:
Name of Health Practitioner	Dale
	(')
Standura of Health Prantitioner	Telephone Number