

Emergency Contact Information

Children's (1) _____
Names (2) _____
(3) _____
(4) _____
(5) _____

Date of Birth (1) _____
(2) _____
(3) _____
(4) _____
(5) _____

Parent's Name _____
Place of Work _____
Home # () _____
Daytime # () _____
Cell # () _____

Parent's Name _____
Place of Work _____
Home # () _____
Daytime # () _____
Cell # () _____

Physician's Name _____
Phone # () _____

Dentist's Name _____
Phone # () _____

Emergency Contact 1 _____
Address _____
City St Zip _____
Phone () _____
Relationship _____

Emergency Contact 2 _____
Address _____
City St Zip _____
Phone () _____
Relationship _____

In the event of an emergency, I hereby give the Wisconsin International School permission to contact the physician and/or dentist listed above, and/or transport any of the above named students to a hospital emergency room.

Parent Signature _____ Date _____