

# 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 \_\_\_\_\_