



**UnityPoint Health**  
Des Moines

## EMERGENCY CONTACT INFORMATION

Child \_\_\_\_\_ Birthdate \_\_\_\_\_

Parent(s) \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

In case of an emergency, contact: \_\_\_\_\_

Mother: At Work \_\_\_\_\_ Phone \_\_\_\_\_

Father: At Work \_\_\_\_\_ Phone \_\_\_\_\_

Other: \_\_\_\_\_ Phone \_\_\_\_\_

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Allergies of Child \_\_\_\_\_

Person(s) authorized to pick up child from Center:

Mother \_\_\_\_\_ Father \_\_\_\_\_

Other \_\_\_\_\_

Signed (Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_