Health Emergency Information
Des Moines Area Community College
Child Development Center/Early Childhood Education

Name: ____ Date of Birth: _____________________________
(Last) (First) (Middle Initial)

In case of an emergency notify one of the below:

1. Name: ______________________________ Relative/other: ______________________________

   City: _______________________________ Home Phone Number: ________________________

   Cell: _______________________________ Work Phone Number: ________________________

2. Name: ______________________________ Relative/other: ______________________________

   City: _______________________________ Home Phone Number: ________________________

   Cell: _______________________________ Work Phone Number:________________________

Health Information:

Name of Primary Care Physician	
Address and Phone of Primary Care Physician	
Name of Dentist	
Address and Phone of Dentist	
Hospital of Choice (name and city)	
Insurance Carrier	
Insurance Number	

Medical History, allergies, drugs taken and any other information which might be of importance:
____
____
____

I give my permission and consent to the staff of the DMACC Child Development Center or DMACC Early Childhood Education program to secure and authorize emergency medical care and/or treatment as I may require. I also agree to pay all of the costs and fees for any emergency medical care and/or treatment.

Signature of Student: _____________________________________ Date:________________________________

Last Updated: 6.10.15