EASTCONN EHS PRENATAL EMERGENCY CONTACT SHEET

Prenatal Mom: _____ Expected date of delivery: _____

Address: _____ Employer: _____

Phone: _____ Address: _____ Phone: _____

Email: _____@_____ Hours of employment: _____

Birth Date: _____ Secondary Adult: _____

Mom's Physician: _____ Address: _____

Physician Phone #: _____ Phone: _____

Mom's OBGYN: _____

OBGYN Phone #: _____

Mom's Specialist: _____

Specialist Phone #: _____

Hospital Preferred: _____Town/location: _____Phone #: _____

Allergies to Food (specify): _____ Reaction: _____

Allergies to Medicine (specify): _____ Reaction: _____

Allergies to Anything else (specify): _____ Reaction: _____

List any medication(s) you may be taking: _____

List any concerns (health/psychological): _____

☐ YES ☐ NO – My Family agrees to receive text messages and/or emails from EASTCONN EHS & HS

I give permission for the following people to be contacted in case of emergency or if I cannot be reached. In the event of an emergency or the need for medical attention concerning myself, I hereby authorize EASTCONN Head Start, its agents, and staff to take whatever action they deem necessary, in their best judgment, to and including taking me to the hospital, doctor, dentist or other medical specialist in a private car, Head Start vehicle or ambulance.

Person(s) to contact in case of emergency. Please use back if additional emergency contacts.

1. Name: _____
   Relationship:_____
   Address: _____
   Telephone: _____

2. Name: _____
   Relationship: _____
   Address: _____
   Telephone: _____

3. Name: _____
   Relationship:_____
   Address: _____
   Telephone: _____

4. Name: _____
   Relationship: _____
   Address: _____
   Telephone: _____

***Emergency Contact* Sheet may be re-signed if there are no changes. If any changes are needed, please complete a new form.**

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____