445 A Willard Ave
Newington, CT 06111

EMERGENCY CONTACTS

Client name: _____

Address: _____

_____ State _____ Zip _____

I hereby authorize immediate medical emergency care if necessary for _____ at the Family Adult Day Care. I also will accept responsibility for emergency care at _____ Hospital and are responsible for all associated fees.

In Case of Emergency/Illness or building closure

1. **First Contact: _____**

Address: _____

_____

Home telephone: _____

Work telephone: _____

Place of employment: _____

Cell phone: _____

2.Second Contact: _____

Address: _____

_____

Home telephone: _____

Work telephone: _____

Place of employment: _____

Cell phone: _____

3.Third Contact: _____

Address: _____

_____

Home telephone: _____

Work telephone: _____

Place of employment: _____

Cell phone: _____

4.Fourth Contact: _____

Address: _____

_____

Home telephone: _____

Work telephone: _____

Place of employment: _____

Cell phone: _____

Signature _____ Date _____