Written Plan in Case of Provider Illness, Injury or Death

****Please make sure you fill out this form completely. Sign and date the at the bottom .**

If I, _____ (name of provider) should get seriously injured, become seriously ill or expire, the designated (qualified) person, listed below, will:

- Notify the parents to come and pick up their children immediately.
- The qualified person, household member named above, will care for the child/ ren.

Qualified Household Member/Caregiver Name: _____

Relationship /Position to provider: _____

Contact phone number: _____

Email address: _____

A qualified substitute caregiver, listed below, will be provided to continue care and will meet all employee/volunteer / household member requirements:

- Drug Test, TB Test, CPR, First AID, and Child Abuse training, Orientation, National Fingerprint Criminal History, and Current completed Consent Form on file with the Office of Early Childhood and Out of School Learning

Person's Name: _____

Relationship to provider / position: _____

Contact phone number: _____

Email address: _____

The children's records are located: _____

Childcare Resource and Referral Agency to assist in finding emergency care: 1-800-299- 1627.

I understand by my signature I agree that the above plans will be followed in case of my illness and a copy of this will be posted in my house at all times.

Provider Signature _____ Date: _____