



ANNUAL EMERGENCY CONTINGENCY PLAN

- 1. In the event of emergency closure, due to any reason that will prohibit the facility from caring for the children Temporarily, the following plan will be in effect:

CONTACT PERSON:

Name of Provider: _____

Address: _____

Telephone: _____
(Area Code)

Pager: _____
(Area Code)

Cell Phone: _____
(Area Code)

Fax: _____
(Area Code)

- 2. The Office of the State Superintendent of Education, Division of Early Childhood Education, Compliance and Integrity Division, Program Monitoring Unit, if applicable and parents/guardians will be notified immediately by telephone and in writing.

- 3. The children will be relocated to the following location: (If more than one (1) location is used please indicate On the back and check this block):

Emergency Provider's Name: _____

Address: _____

Telephone: _____
(Area Code)

Pager: _____
(Area Code)

Cell Phone: _____
(Area Code)

Fax: _____
(Area Code)

- 4. The children will be transported by: Foot Bus Car/Van Other _____
Any cost involved in transporting the children will be paid by:
 Provider Parent Not Applicable

- 5. In the event of emergency closure due to any reason that will prohibit the facility from caring for the children Permanently; the children will be referred to other licensed child development facilities.

Signature of Provider

Date

- 6. I have read this agreement and grant the provider named above permission to use my facility in case of emergency evacuation of the provider's facility.

Signature of Emergency Provider

Date