

Emergency Contact and Health Card 2010-11

**Please complete all sections and return to the preschool as soon as possible.
Also, provide any updates as they occur throughout the school year.**

Last Name _____	First Name _____	Birth date _____
Home Address _____		Home Phone _____
Family Email Address _____		Closest FCPS Elementary School _____

Regular Caregiver _____ Phone (____) _____

Father _____ Work # (____) _____ Cell # (____) _____

Employer Name & Location _____

Mother _____ Work # (____) _____ Cell # (____) _____

Employer Name & Location _____

Marital Status: Married Widowed Separated Divorced **Custody:** Mother Father Joint **Resides With:** Mother Father

Child CANNOT be released to: _____

Languages spoken at home: _____

Emergency Contacts and Release					
If it is necessary to contact parents during the school day, staff will first call the child's home, then parents at work. If neither is available, the preschool is authorized to release my child to any of the following persons: (Contacts need to be within 15 minutes of the school.) Two persons, other than parents above, are required.					
Name	Relationship	Phone 1	Phone 2		
_____	_____	_____	_____	H W C	H W C
_____	_____	_____	_____	H W C	H W C
_____	_____	_____	_____	H W C	H W C
Out of Area Contacts for use during a Community Emergency (at least 2 hours away)					
Name	Relationship	Phone 1	Phone 2		
_____	_____	_____	_____	H W C	H W C
_____	_____	_____	_____	H W C	H W C

Current Health/Medical Information

Please CHECK any health conditions that preschool staff needs to be aware of or may require attention during the school day. If none, please check here:

- | | |
|--|--|
| <input type="checkbox"/> ALLERGIES: (be specific & complete Action Plan)
<input type="checkbox"/> Foods: Peanut Dairy Wheat Other (Specify)
<input type="checkbox"/> Medicines
<input type="checkbox"/> Bee stings or insect bites
<input type="checkbox"/> Other
<input type="checkbox"/> ASTHMA _____ | <input type="checkbox"/> HEART PROBLEM
<input type="checkbox"/> PHYSICAL LIMITATIONS _____
<input type="checkbox"/> RESPIRATORY _____
<input type="checkbox"/> SEIZURES _____
<input type="checkbox"/> VISION PROBLEMS _____
<input type="checkbox"/> OTHER _____ |
|--|--|

List all medications and dosages your child receives on a continual basis:

Separate authorization is required for preschool staff to administer any medication to your child.

Physician Information			
My child's medical care is provided by: _____			
	Name of Doctor	Location	Phone
My child's medical coverage is provided by: _____			
	Policy No.	Location	Phone
	Health Insurance Co./HMO		

Redeemer Lutheran Preschool staff has my permission, in an emergency, to secure appropriate medical care for my child. The medical staff has my authorization to provide necessary medical treatment for the well-being of my child.

Parent Signature _____ Date _____ Updated _____

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Student Information Sheet

Child's Name to be used at school: _____

What other preschools/daycares has your child attended (not classes)? None

Name

Location

Dates attended

Allergies/health concerns (if any):

Any significant changes in your child's life recently (birth, death, caregiver)?

Tell me about your child's strengths/special abilities:

Tell me about your child's weaknesses/fears:

What is your child's favorite subject/activity?

Does your child have any concerns about this year?

Tell us anything else you think we should know:

What is your goal(s) for preschool education?

What is the best way to contact parents? (Circle one) Phone Email

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