

Health Information

Emergency Contact (when parents cannot be reached)

Name: _____ Phone #: _____

Relationship: _____

Doctor or healthcare provider to call: _____

Phone #: _____

Special health problems? Please specify: _____

Regular Medications? Please specify: _____

Allergies, including drug reactions? Please specify: _____

Other important information: _____

Consent to medical care and treatment of minor children

I give permission that my child, _____, may be given first aid/emergency treatment by a qualified child care provider and/or staff at Grace Lutheran Church and Preschool.

When I cannot be contacted, I authorize and consent to medical, surgical, and hospital care, treatments and procedures to be performed for my child by a licensed physician, healthcare provider, hospital or aid car treatment when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I certify under penalty of perjury under the State of Washington that this information is true and correct.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

General Information

What name does your child go by: _____

Has your child attended preschool before (circle one): YES / NO

If yes, which one: _____

Reason for change: _____

Major family Changes (past, present, future): _____

Languages spoken at home: _____

Child's Interests: _____

Strongest personality traits: _____

What should we know about your child: _____

Do you, as a parent/guardian, have any special talents or hobbies you would be willing to share with the class? Yes ___ No ___

Please specify: _____

FOR OFFICE USE ONLY:

Date Received: _____

Registration paid: _____ Date: _____