

EMERGENCY CONTACT INFORMATION:

Name of child's doctor _____ Office Phone _____

Address _____ Zip code _____

Name of child's dentist _____ Office Phone _____

Address _____ Zip code _____

Hospital preference _____ Phone _____

If neither father or mother (or guardian) can be contacted, call (please list relationship)

Name _____ Relationship _____

Home Phone _____ Office Phone _____ Cell Phone _____

Name _____ Relationship _____

Home Phone _____ Office Phone _____ Cell Phone _____

In the event I cannot be reached to make arrangements for emergency medical attention, I authorize Crossroads S.T.A.R.S. Preschool Staff to make those arrangements. I give consent for any and all treatment deemed necessary by the attending physician.

(Signature of Parent) (Date)

My child will need to have the following medication(s) at school _____

I give permission for my child's photo to be used for school projects or displayed in the classroom. YES NO

I give permission for my child's photo to be displayed in the church hallways YES NO

I give permission for my child to take campus walks with supervision around the church YES NO

INFORMATION ABOUT YOUR CHILD

Does your child have any known health concerns (i.e. allergies, asthma, etc.) No ___ Yes _____

Explain:

Please give us any information concerning your child which will be helpful in his/her experience in group setting (such as play, eating habits, special fears, special likes and/or dislikes, speech or hearing difficulties)