

**St. Jerome Little Lions Preschool
Emergency Information
2015 - 2016**

FAMILY INFORMATION

Student Name _____ Class _____
Address _____ City _____ State _____ Zip _____
Home Telephone # (____) _____ Primary E-Mail Address _____
Date of Birth _____ Place of Birth _____
Public School District _____

PARENT/GUARDIAN INFORMATION

Student lives with Parents Mother Father Other _____
Father's/Guardian's Name _____ Home Tel #(____) _____
Employer _____ Work Tel
#(____) _____
Cell Tel # (____) _____

Mother's/Guardian's Name _____ Home Tel #(____) _____
Employer _____ Work Tel
#(____) _____
Cell Tel # (____) _____

CHILD CARE PROVIDER INFORMATION

Child Care Provider's Name: _____ Relationship _____
Home Tel # (____) _____ Cell Tel #
(____) _____

MEDICAL/PHYSICAL INFORMATION

Doctor's Name _____ Tel # (____) _____
Hospital Preference _____ Second Choice

Insurance Company _____ Policy No. _____ Group No.

Dentist Name _____ Tel # (____) _____

STUDENT HEALTH INFORMATION

Student's Name _____ Date of Birth _____

Class/Teacher _____ Home Tel # _____

Does your child have a history of the following conditions? If so, please explain type of medical treatment.

YES NO

____ ADD/ADHD

____ Asthma _____

____ Diabetes _____

____ Food or Drug Allergy

____ Bee Sting Allergy

____ Seizure Disorder _____

____ Condition Limiting Physical Education

____ Migraine Headaches _____

____ Other Chronic or Recurrent Conditions _____

____ Glasses/Contacts (Please Circle) (When to be worn) _____

____ Currently in Speech or Occupational Therapy _____

____ Presently Taking Medications

Names of Medication	Reasons for Taking Medication
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_____	_____
_____	_____
_____	_____

In the event that my child should become seriously ill or injured while _____ and require prompt emergency care, I give my permission to the attending physician for any necessary emergency medical treatment.

Parent/Guardian Signature

Parent/Guardian Signature

Date

PRINT Parent/Guardian Signature

PRINT Parent/Guardian Signature

Date