St. Jerome Little Lions Preschool
Emergency Information
2019-2020

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
____
____
____

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