

***Please submit with initial registration.**

Child Emergency/Health Information Form

Child's Name _____ Birth Date _____

Child's Address _____
City _____ Zip Code _____

Child's Home Phone _____

Parent/Guardian's Name _____ D.O.B. _____

Address (if different from child's) _____

Place of Employment _____ Occupation _____

Work Address _____ Work Phone _____

Phone where parent can be reached when child is in school _____

Email Address _____

Parent/Guardian's Name _____ D.O.B. _____

Address (if different from child's) _____

Place of Employment _____ Occupation _____

Work Address _____ Work Phone _____

Phone where parent can be reached when child is in school _____

Email Address _____

Who most likely will be dropping your child off in the morning?

Name _____ Relationship _____

Who most likely will be picking your child up in the afternoon?

Name _____ Relationship _____

EMERGENCY CONTACTS: If we are unable to reach you directly, please list at least ***TWO LOCAL CONTACTS*** who could we call in case of an emergency, who are ALSO authorized to pick up your child(ren).

REQUIRED:

1. Name _____ Relationship _____

Address _____ Phone Number _____

2. Name _____ Relationship _____

Address _____ Phone Number _____

Additional contacts who have permission to pick up your child(ren):

Name _____ Relationship _____

Address _____ Phone Number _____

Name _____ Relationship _____

Address _____ Phone Number _____

Is there anyone who does NOT have permission to take your child from school?

Name _____ Relationship _____

Address _____ Phone Number _____

PLEASE NOTE: A copy of the court decision must be on file in order for the school to not release a child to his/her non-custodial parent. (A picture should be provided if anyone is listed above).

Physician's Name/Clinic: _____

Physician's Address _____

Physician's Phone _____

My child takes the following medications: _____

This medication affects my child in the following way(s): _____

* My child is **allergic** to the following foods/and has the following special diet instructions: _____

My child has special health concerns as follows: _____

Dentist's Name _____

Dentist's Address _____

Dentist's Phone Number _____

Note: If you do not have a dentist please check yes below to allow us to list Peace of Mind's preferred dentist, Woodbury Smiles, as your child's dentist.

Yes ___ No ___ (if no, please list your own preferred dentist even if your child has not yet been seen)

***Note:** If your child has any special diet requests or true allergies, please ask for the supplemental diet/allergy form and arrange a time to talk with the chef or director prior to your child's start date.