Preschool
HEALTH & EMERGENCY CONTACT INFORMATION

Child's Full Name:_____ DOB:_____ AGE:_____
Primary Address:_____ City:_____ Zip:_____
Address 2 (if applicable):_____

Primary Care Physician:_____
Address: _____
Phone: _____

Dentist:_____
Address:_____
Phone: _____

Hospital of Choice: _____
Address: _____

Hospital Phone: _____

(Contact this parent first)
Parent Name:_____
Work Phone:_____ Cell Phone:_____
Employer:_____
Address: _____
Email:_____

(Contact this parent second)
Parent Name:_____
Work Phone:_____ Cell Phone:_____
Employer:_____
Address: _____
Email:_____

List in order of contact preference:

1. Name: _____
Address: _____
Phone #: _____

2. Name: _____
Address: _____
Phone #: _____

3. Name: _____
Address: _____
Phone #: _____

4. Name: _____
Address: _____
Phone#: _____

Are there any custody agreements, restraining orders, or any other information of which we should be aware? If so, please describe: _____
_____

Health Information

If your child has asthma, severe allergies, or needs medication administered, a separate health plan form must be filled out. This may be obtained from the school office or downloaded at www.zionsaintsbethalto.org.

Allergies: Yes _____ No _____ Asthma: Yes _____ No _____ Special Diet: Yes _____ No _____
Medications: Yes _____ No _____ History of Seizures: Yes _____ No _____
Vision Impairment: Yes _____ No _____ Hearing Impairment: Yes _____ No _____
Use of Special Adaptive Equipment: Yes _____ No _____

If answered yes above, please explain below. Also include any other important conditions of which attending medical personnel should be aware (i.e. heart, respiratory, drug reactions, etc.):
_____
_____
_____

Medical Emergency Authorization

In the event neither parent can be notified, I hereby give my consent for the administration of any treatment deemed necessary by (Preferred Physician)_____or in the event the designated practitioner is not available, by another licensed physician, and the transfer of the child to (Preferred Hospital) _____, or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians, concurring in the necessity for such surgery are obtained, prior to the performance of such surgery.

Date_____ Parent's Signature_____