## EMERGENCY INFORMATION

Child's Name _____ Birth Date _____

Address _____

Mother's Name _____ Daytime Phone _____

Father's Name _____ Daytime Phone _____

In the event of an emergency, St. Paul Lutheran Preschool is authorized to obtain Emergency Medical or Dental Care even if the Preschool is unable to immediately make contact with the parents/guardian. During an emergency the Preschool is authorized to contact the following persons when parent/guardian cannot be reached:

1) Name _____ Relationship _____

Daytime Phone _____ Cell Phone _____

2) Name _____ Relationship _____

Daytime Phone _____ Cell Phone _____

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Child's Doctor _____ Phone _____

Doctor's Address _____

Child's Dentist _____ Phone _____

Dentist's Address _____

Date of last Dental Exam_____

Hospital Preference _____

Insurance Company _____

Policy holder's name _____

Policy number _____

**ALL INFORMATION IS REQUIRED, PLEASE DO NOT LEAVE ANY BLANK**

## HEALTH INFORMATION

Does your child have any health problems of which we should be aware, such as:

____ Bee Sting ____ Convulsions (Epilepsy) ____ Other

____ Asthma ____ Diabetes ____ Heart Condition

____ Allergies or health concerns (please list) _____

_____

Does your child take medication(s) regularly? Y N

If so, what medication(s) and how often? _____

_____

Describe any known medical history that is important to know for medical treatment: _____

_____

Date of last tetanus: _____

**I agree to pay the costs and fees contingent on any emergency medical and/or dental care for my child as secured or authorized under this consent.**
**This consent will be in effect beginning September 1st and continue while the child is enrolled in St. Paul Lutheran Preschool**

Parent/Guardian Signature _____

Date _____