Shepherd of the Hills Lutheran Preschool

Emergency Information & Immunization Record Card

Child's Name: _____ Date Enrolled: _____

Home Address: _____ Date of withdrawal: _____
Street City State Zip

Home Phone: _____ Date of Birth: _____ Sex: male female

Mother or Guardian
Name:_____

Home Address:_____
☐ SAME AS ABOVE Street City State Zip

Home Phone:_____ Cell Phone:_____

Business Name:_____ Work Phone:_____

Business Address:_____
Street City State Zip

Signature:_____

Father or Guardian
Name:_____

Home Address:_____
☐ SAME AS ABOVE Street City State Zip

Home Phone:_____ Cell Phone:_____

Business Name:_____ Work Phone:_____

Business Address:_____
Street City State Zip

Signature:_____

If Medical Care is Necessary, Call: (please fill out all the information address, etc..)

DOCTOR:_____
Name Address City State Zip Phone

HOSPITAL: _____
Name Address City State Zip Phone

DENTIST: _____
Name Address City State Zip Phone

Does your child have insurance coverage? ☐ **No** ☐ **Yes** Name of Insurance Company_____
(Optional)

In case of injury or sudden illness 911 will be called first. _____will be called first after the 911 call. I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

In case of an emergency, or if I cannot be contacted to pick up my child, I hereby authorize the following person(s) to pick up my child.

Name:_____ Name:_____

Address:_____ Address:_____
Street City State Zip Street City State Zip

Telephone:_____ Cell phone:_____ Telephone:_____ Cell phone:_____

Name:_____ Name:_____

Address:_____ Address:_____
Street City State Zip Street City State Zip

Telephone:_____ Cell phone:_____ Telephone:_____ Cell phone:_____

The following person(s) may **not** remove my child from the center:

Name:_____ Name:_____

Custody papers have been provided and are on file at the facility. ☐ Does not apply ☐ No ☐ Yes

Immunization Information

Check one

	Copy of current official documented immunization record on file at the facility
	Religious Belief exemption form signed by parent/guardian on file at the facility
	Medical Exemption form signed by physician and parent/guardian on file at the facility

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Medical Information

(If you mark "Yes" to any of the below questions, a Health Action Plan will need to be on file for you child. Please contact the Preschool for more information,)

Does your child take any medication on a regular basis? □ **No** □ **Yes** If yes, please list all medications, reason for medication and use information. _____

_____

Is child allergic to food or other substances? □ **No** □ **Yes** If yes, name foods or substances to be avoided and procedure to follow if reaction occurs._____

_____

Is your child allergic to bee stings? □ **No** □ **Not Sure** □ **Yes** If yes, you are required to supply a current prescription EpiPen.

Is child usually susceptible to infections and if so, what precautions need to be taken? □ **No** □ **Yes** _____

_____

Does your child have asthma? □ **No** □ **Yes** If yes, please provide a current prescription inhaler?

Is your child subject to convulsions and what should be our procedure if one occurs? □ **No** □ **Yes** _____

_____

Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, diabetes, hearing impairment, hernia, etc.)? □ **No** □ **Yes** _____

_____

Additional comments: _____

_____

Other special instructions: _____

_____

This **Emergency Information** is accurate and complete, front and back, and was provided by:

_____ Date:_____

Parent or Guardian printed name Signature