

# Little Peaches Preschool Child Record Form

Today's Date: \_\_\_\_\_ Child's Date of Birth: \_\_\_\_\_

Child's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Zip code: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent #1: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employers Name: \_\_\_\_\_

Work phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent #2: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employers Name: \_\_\_\_\_

Work phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emails: \_\_\_\_\_

Names of siblings:

\_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_ Age \_\_\_\_\_

**Medical information:**

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Insurance information:**

Insurance company: \_\_\_\_\_

Name of subscriber: \_\_\_\_\_ Id number \_\_\_\_\_

PARENTS ARE RESPONSIBLE FOR ALL EMERGENCY MEDICAL TREATMENTS.

In case of emergency contact: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ phone: \_\_\_\_\_

Other than the above parent/guardians, only the following person(s) may remove your child from care without previous notice. PHOTO ID WILL BE REQUIRED.

<b>Name</b>	<b>Relationship</b>	<b>Phone</b>
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**Please list all allergies here:**

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**Please list any other information below that you believe I should be aware of as your child's preschool teacher:**

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**If any of the above information ever changes, please make me aware so that I may update your file.**

**\*\*\*Please return this form to Little Peaches along with updated shot records for your child as well as your Enrollment check of \$100.00 (non-refundable/to hold your spot) and thank you for choosing Little Peaches!\*\*\***

**Please Sign and Date below stating you have read the parent handbook and agree to all of the terms.**

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Abby Lazarus  
Little Peaches Preschool  
1805 E 19th St, Cheyenne, WY 82001  
307-220-3051

Emergency Medical Authorization- Required by DFS

Childs Name: \_\_\_\_\_

Doctors Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Information such as allergies, chronic conditions or frequent hospitalizations:

\_\_\_\_\_  
\_\_\_\_\_

Social or Family information or special concerns: \_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_ hereby give permission to Little Peaches

Preschool and all staff to obtain medical or surgical care from a health care facility,

physicians or dentist for my child, whose full name is \_\_\_\_\_

\_\_\_\_\_ and date of birth is \_\_\_\_\_,

should the need arise.

It is understood that a conscious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by medical personnel may be taken. I further consent to transportation, by the provider or ambulance, of the above named child to the nearest or most appropriate medical facility.

Signature \_\_\_\_\_ Date \_\_\_\_\_