Little Peaches Preschool Child Record Form

Today's Date: ________________ Child's Date of Birth: ________________

Child's Full Name: ____

Address: ____

Zip code: ___________ Phone: _______________________

Parent/Guardian#1: _________________________________

Occupation: __________________________ Employers Name: ____________________________

Work phone: ________________ Cell Phone: __________________

Parent/Gaurdian #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.

Name	Relationship	Phone
____________________	____________________	_____________
____________________	____________________	_____________

Please list all allergies here:

____

____

____

____

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.

____

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, _____________________________________ herby 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_________________________