School Year: 201___-201____

STUDENT INFORMATION SHEET

Student's Full Name _____

Name Child will use in school (Matthew, Matt) _____

Date of Birth _____ Enrollment Date: _____

Which class would you like, if available?

3-year old (T/TH) AM_____ 4-year old (M/W/F) AM _____

3/4-year old PM _____ Which Days (PM class only)?: _____

Is child baptized? _____Church Where Baptized _____

Church home _____

Mother's Name_____

Address_____

Street City Zip

Employer _____

Address_____

Street City Zip

Mother's Phone _____ Work number_____

Email Address_____

Father's Name_____

Address_____

Street City Zip

Employer_____

Address_____

Street City Zip

Father's Phone _____ Work number_____

Email Address_____

Brothers and Sisters (Names and Ages)

1. _____
2. _____
3._____

What is the best way to reach you when your child is in our care?

_____

_____

Why would you like to enroll your child at Lord of Life Lutheran Preschool?

_____

_____

Are there any special things we should know about your child?
(Afraid of anything, bathroom habits)

_____

_____

What goals would you like your child to achieve this year?

_____

_____

Anything else you would like us to know?

_____

_____

_____

_____

HEALTH CARE PROVIDER INFORMATION

PLEASE FILL OUT COMPLETELY AND SIGN BELOW

Child's Physician_____

Name

_____

Address Phone

Child's Dentist_____

Name

_____

Address Phone

Hospital Choice _____

CHILD'S HEALTH INFORMATION

Briefly tell about your child's general health:

_____

_____

Any chronic medical problems? _____

_____

Any allergies? _____

_____

Any diet restrictions? _____

_____

X_____ X _____

Signature of Father and/or Signature of Mother

EMERGENCY MEDICAL TREATMENT CONSENT FORM

In the event that my child, _____, sustains a serious or life threatening injury while at the school, I give the school permission to seek emergency medical care for my child.

x_____

Signature Date

EMERGENCY CONTACT INFORMATION

In case of an emergency and we the parents/guardians cannot be immediately reached, the following people may be contacted in the order listed below. My child can be released to the following individuals.

Name Address Phone

1. _____

_____

2. _____

_____

3. _____

_____

AUTHORIZED PICK UP

The following people have authorization to pick my child up from school.

Name Address Phone

1. _____

_____

2. _____

_____

3. _____

_____

HANDBOOK FORM

We have read and understand all materials presented in the Lord of Life Preschool Handbook.

x_____

Signature Date

Obtain a signed Immunization Certificate from your child's doctor. An official copy of your child's immunization record that is signed by your health-care provider will also be accepted. Return it with your enrollment packet.

CHILD'S STATEMENT OF HEALTH STATUS FOR ENROLLMENT IN A CHILD CARE FACILITY

The child care facility must obtain for every child who enrolls in child care programs a signed and dated statement of the child's current health status which indicates the child's abilities and/or limitations to participate in a regularly schedule child care program. This report is to be filled out by a licensed physician or other health care professional who has seen the child in the last twelve months.

Name of Facility _____ Type of Facility_____

Child's Name _____ Sex _____ Date of Birth _____

Address_____

Past illnesses – check those the child has had and give approximate dates:

Chicken Pox _____ Rubeola_____ Rubella_____Rheumatic Fever _____ Asthma_____

Hay Fever_____Diabetes_____ Mumps_____ Epilepsy_____ Whooping Cough_____

Poliomyelitis _____ Other _____

Comments_____

Surgery/Accidents/Illness/Chronic Health Problems

_____

_____

Describe any physical condition requiring the facility's special attention:

_____

_____

Medication(s) prescribed: _____

Allergies:_____ and prescribed routine_____

If tuberculin test given: Date _____ Result _____

If chest x-ray taken: Date _____ Result _____

Vision _____ Hearing _____

Please record immunizations and date administered on the Colorado Department of Health Certificate of Immunization and attach to this form.

Date of my recent examination of the child: _____

X_____ _____

Signature of licensed physician or other health care professional **Date**

Please Print:

Name of Physician/Health Care Professional _____

Address City State Zip _____

Phone_____