Holy Trinity Preschool

Where children love to learn and learn God's love

Emergency Information

Name of Child:_____ Date of Birth:_____

Address:_____ Phone _____

Father's Name:_____ Mother's Name:_____

Father's Employer _____Phone_____ Hours_____

Mother's Employer _____Phone_____ Hours_____

Day Care Provider/Sitter _____Phone _____

Cell Phone Numbers: Mother _____ Father _____ Sitter_____

Email Address for Parents/Guardian _____

Person to be called in an emergency (other than parent). Please include someone who usually knows your whereabouts.

Name_____ Relationship to child _____

Address_____ Phone_____

Child's Physician _____ Phone_____

We, the parent(s) or legal guardian(s) of the above named child, appoint Holy Trinity Preschool to act in my/our behalf in authorizing emergency medical, dental or surgical care and hospitalization in the event that I/we cannot be contacted.

We also give this child permission to participate in activities sponsored by Holy Trinity Preschool.

Parent/Guardian Signature_____Date_____

over, please

Revised August 2013

Medical Information Form

Name of Child:_____ Date of Birth:_____

Address:_____ Phone _____

Date of last physical examination _____

History:

Allergies _____

Chicken pox _____

Diabetes_____

Epilepsy_____

Measles_____

Mumps_____

Rheumatic Fever _____

Tuberculosis_____

Whooping Cough _____

Asthma_____

Chronic sore throat _____

Chronic colds _____

Chronic ear aches/infections _____

Nosebleeds _____

Drug sensitivity/allergy _____

Record of Immunizations (attach copy to this form or fill out below):

	1st Dose	2nd Dose	3rd Dose	4th Dose
DPT	_____	_____	_____	_____
Polio	_____	_____	_____	_____
MMR	_____	_____	_____	_____

Are there any medical conditions/accidents/operations that we should be aware of?

Parent/Guardian Signature_____ Date_____