

STUDENT'S FIRST NAME

STUDENT'S LAST NAME

Sex: ___ Male ___ Female

Child's Physician _____

Phone # _____

Clinic Address: _____

Date of Child's Last Physical Exam _____

Share any health concerns or chronic medical conditions that you believe would be important for **Trinity Lutheran Preschool** and its staff to know while your child is in our care:

Allergies: Check all that apply: ___Foods ___Plant s ___ Bee/Insects ___ Animals ___Other

List Food/Other Allergies:

FOOD/OTHER

ALLERGIC REACTION

If Signs of a reaction occur, please list instructions of how you would like us to respond, in order.

1. _____
2. _____
3. _____

Is medication or Epi-Pen needed for allergy? ___YES ___NO

If medications and/or an epi-pen will be needed to administer to a child in an emergency situation, we need to have a current Doctor's prescription with instructions for dosage and circumstances under which medication is to be administered. We need to have the medication at school at all times and labeled with your child's name in a baggie. A conference with staff is required each year your child is enrolled.

Other than allergy, does your child have any food restriction?

(Cultural, Religious, Personal)? ___no ___yes describe:

***You may need to bring a snack for your child every day in case they cannot eat the classroom snack provided by the other parents.**

Please communicate with your child's teachers about this.

Is your child taking medication at home for any ongoing condition? ___no ___yes

If yes, please describe: _____

HAS YOUR CHILD:

If Yes, What was the result?

Had a hearing test? yes no _____

Had an eye exam? yes no _____

Had a speech/communication evaluation? yes no _____

Do you have any concerns about your child's behavior? no yes, describe:

Do you have any concerns about your child's development? no yes, describe:

ADDITIONAL CONCERNS:

DENTAL HISTORY

Name of Dentist : _____ City/State _____ Phone _____

Has your child seen a dentist? no yes

Signature of Parent or Guardian **Date**

CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILD

I hereby give permission that my child, _____ may be given treatment by a qualified **Trinity Lutheran Preschool** employee at **Trinity Lutheran Preschool**. When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or emergency technician (EMT) when deemed necessary or advised by the physician or EMT to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

Parent/Guardian Signature **Date**