

Please fill out BOTH SIDES of this form.

**DIOCESE OF ALLENTOWN
St. Theresa Preschool
Emergency Information 2023-2024**

1. FAMILY INFORMATION

Student Name _____ Grade _____
Address _____ City _____ State _____ Zip _____
Home Telephone Number _____ Home E-Mail Address _____
Date of Birth _____ Place of Birth _____
Public School District _____

2. PARENT/GUARDIAN INFORMATION

Student lives with (circle one) Parents Mother Father Other _____

Father/Guardian's Name _____ Home Telephone _____

Employer _____ Work Telephone _____ Ext. _____

Cell Phone Number _____ E-Mail _____

Mother/Guardian's Name _____ Home Telephone _____

Employer _____ Work Telephone _____ Ext. _____

Cell Phone Number _____ E-Mail _____

Parents/Guardians listed above have permission to pick-up the child unless otherwise indicated. Notify the Pre-School Director immediately if there are any court orders restricting non-custodial parents or others from contact with the child. Provide the Director with a copy of the court order.

3. CHILD CARE PROVIDER INFORMATION

Those designated below are authorized to pick up my child from the school in an emergency.

Child Care Provider's Name _____ Relationship to the Child _____

Home Telephone Number _____ Work Telephone _____ Ext. _____

Cell Phone Number _____ E-Mail _____

4. LOCAL CONTACT INFORMATION

1. Child Care Provider's Name _____ Relationship to the Child _____

Home Telephone Number _____ Work Telephone _____ Ext. _____

Cell Phone Number _____ E-Mail _____

2. Child Care Provider's Name _____ Relationship to the Child _____

Home Telephone Number _____ Work Telephone _____ Ext. _____

Cell Phone Number _____ E-Mail _____

5. MEDICAL/PHYSICAL INFORMATION

Doctor's Name _____ Telephone Number _____

Hospital Preference _____ Second Choice _____

Insurance Company _____ Policy No. _____ Group No. _____

Dentist's Name _____ Telephone Number _____

In a medical emergency, we hereby authorize the Preschool to seek emergency medical assistance for our child if we cannot be reached.

Parent/Guardian Signature

Parent/Guardian Signature

Date

Please keep a copy of this form for your records. IMPORTANT: Please update the Preschool immediately if any information changes.

STUDENT HEALTH INFORMATION

Student's Name _____ Date of Birth _____

Grade/Teacher _____ / _____ Cell Phone _____

Does your child have a history of any of the following conditions? If so, Please explain type of medical treatment.

YES NO

_____ _____ ADD/ADHD _____

_____ _____ Asthma _____

_____ _____ Diabetes _____

_____ _____ Food or Drug Allergy _____

_____ _____ Bee Sting Allergy _____

_____ _____ Seizure Disorder _____

_____ _____ Condition Limiting Physical Education _____

_____ _____ Migraine Headaches _____

_____ _____ Other Chronic or Recurrent Conditions _____

_____ _____ Glasses (When to be Worn) _____

_____ _____ Presently Taking Medications

Names of Medication

Reasons for Taking Medication

In the event that my child should become seriously ill or injured while in school and require prompt emergency care, I give my permission to the attending physician for any necessary emergency medical treatment.

Parent/Guardian Signature

Parent/Guardian Signature

Date

Please Print name of Parent/Guardian

Please Print name of Parent/Guardian

Date