

Age at admission \_\_\_\_\_  
DOB \_\_\_\_\_  
Primary Language \_\_\_\_\_  
Allergies \_\_\_\_\_

### Contact Numbers and Emergency Information

Student name: \_\_\_\_\_ D.O.B \_\_\_\_\_

Address: \_\_\_\_\_ Allergies \_\_\_\_\_

Mother/Guardian \_\_\_\_\_ Father/Guardian \_\_\_\_\_

Contact #'s

Mother (C) \_\_\_\_\_ Father (C) \_\_\_\_\_

### Emergency Contacts:

(1) Name \_\_\_\_\_ Address \_\_\_\_\_

Phone number \_\_\_\_\_ Relationship to child \_\_\_\_\_

(2) Name \_\_\_\_\_ Address \_\_\_\_\_

Phone number \_\_\_\_\_ Relationship to child \_\_\_\_\_

### Authorization for Student Release (other than parents for dismissal or emergency)

(1) Name \_\_\_\_\_ Address \_\_\_\_\_

Phone number \_\_\_\_\_ Relationship to child \_\_\_\_\_

(2) Name \_\_\_\_\_ Address \_\_\_\_\_

Phone number \_\_\_\_\_ Relationship to child \_\_\_\_\_

### Authorization and Consent

I understand that every effort will be made to contact me in the event of an emergency regarding medical attention for my child, \_\_\_\_\_. However, if I cannot be reached or when delay would be dangerous to my child's health, I hereby authorize Preschool for Creative Beginnings, Inc to transport my child to the nearest hospital and to secure for my child the necessary treatment. I understand that the staff members are trained in the basics of Pediatric First Aid and I authorize them to administer First Aid and/or CPR when needed.

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

### Insurance Information (optional)

Company name \_\_\_\_\_ Policy # \_\_\_\_\_

Participating Hospital \_\_\_\_\_