Fox Chapel Presbyterian Church Preschool

CHILD INFORMATION FORM

____
Date

Family

Program / Year ______________________ DOB / Age ______________ M /F

Child's Name/Nickname ______________________________________

Home Address ______________________________ Phone # __________

Father's Name ___________________________ Occupation __________

Address ____________________________________ Phone # __________

Mother's Name ___________________________ Occupation __________

Address ____________________________________ Phone # __________

List name(s) and age(s) of siblings ____________________________

____

____

Name of care giver(s) ______________________ Relationship __________

______________________ __________

Kind of pet(s) and the name(s)

____

____

Health

Primary Care Physician ______________________ Phone # __________

Address ____

List food or drug allergies _____________________________________

List daily medications and purpose ______________________________

(Please complete the reverse side)

EMERENCY CONTACT/PARENTAL CONSENT FORM

Adapted from 55 PA Code Chapt. 3270 DPW

CHILD'S NAME	BIRTH DATE
ADDRESS	
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
	CELL PHONE NUMBER
ADDRESS	EMAIL ADDRESS
MOTHER'S BUSINESS NAME	BUSINESS TELEPHONE NUMBER
BUSINESS ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
	CELL PHONE NUMBER
ADDRESS	EMAIL ADDRESS
FATHER'S BUSINESS NAME	BUSINESS TELEPHONE NUMBER
BUSINESS ADDRESS	
EMERGENCY CONTACT PERSON(S)	**TELEPHONE/CELL NUMBER WHEN CHLID IS IN CARE**
PERSONS TO WHOM CHILD MAY BE RELEASED/ADDRESS	**TELEPHONE/CELL NUMBER WHEN CHLID IS IN CARE**
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	**TELEPHONE NUMBER**
PHYSICIAN'S ADDRESS	
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL OR DIETARY INFO. NECESSARY IN AN EMERGENCY SITUATION	MEDICATION SPECIAL CONDITIONS
ADDITIONAL INFO. ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT	
OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST-AID PROCEDURES
WALKS AND TRIPS	TRANSPORTATION BY THE FACILITY
PHOTOGRAPHS TAKEN	PHOTOGRAPHS USED FOR PUBLICITY

Signature of Parent or Guardian ____________________ Date ____________

A Ministry of the Fox Chapel Presbyterian Church 384 Fox Chapel Road, Pittsburgh, Pa 15238-23985
Phone: 412-963-8243 Fax: 412-967-9134

HEALTH ASSESSMENT FORM

Name ____________________ ( ) Male ( ) Female

Address ____________________ Date of Birth: ____________

City, State, Zip ____________________ Telephone

Name of Parent(s)/Guardian ____________________

Primary Health Care Physician: ____________________
Name
____
Address
____
Telephone

Dentist/Other Medical Specialists: ____________________

____

Does your child have any ongoing medical conditions/mental or physical challenges? ________

____

Please list any allergies your child has: ____________________

____

Please list any medications your child takes and the doses: ____________________

____

****Please attach a copy of your child's immunization records**

To be completed by your physician:

I certify that ____________________ has received a complete examination and is physically and emotionally able to attend the early childhood programs.

____________________ Physician Signature

____________________ Date

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