

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 **HARBOUR POINTE CHRISTIAN PRESCHOOL** and its staff to know while your child is in our care:

\_\_\_\_\_

Allergies: Check all that apply: \_\_\_Foods \_\_\_Plants \_\_\_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:**

Had a hearing test? yes no Please list any concerns:\_\_\_\_\_

Had an eye exam? yes no Please list any concerns:\_\_\_\_\_

Had a speech/communication evaluation? yes no Please list any concerns:\_\_\_\_\_

Is your child currently receiving speech therapy? no yes

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 *Harbour Pointe Christian Preschool* employee at *Harbour Pointe Christian 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 Parent/Guardian Signature Date