

Parent(s) of this child are:

Married
 Widowed

Divorced
 Single

Separated



Please list siblings of this child

_____ Age _____ School _____

_____ Age _____ School _____

_____ Age _____ School _____

Is this child adopted? _____ If so, is the child aware of the adoption? _____

Does this child speak English? _____

Language(s) spoken at home other than English _____

Describe child's previous preschool/daycare experience _____

Family's Place of Worship _____

Your expectations for this year _____

Tell us about your child: special interest, fears, etc. _____

List special talents, cultural background or things about your occupation that you would be willing to share with the children _____

PERSONS (other than parents) AUTHORIZED TO PICK UP:



1. NAME _____
Relationship to child _____
Phone _____

2. NAME _____
Relationship to child _____
Phone _____

3. NAME _____
Relationship to child _____
Phone _____

NOTE: Please inform the director and your child's teachers if there are persons explicitly NOT allowed to pick up your child.

STONEBRIDGE PRESCHOOL

3700 Prosperity Church Road

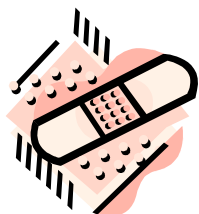
Charlotte, NC 28269

(704) 548-9929

EMERGENCY TREATMENT RELEASE

I hereby authorize StoneBridge Preschool, or its representatives, to obtain emergency medical treatment and/or related services (e.g. transportation to a medical facility, etc.), for my child, _____, in the event that I, or those persons I have designated, cannot be reached.

Parent Signature



Date

Child's Physician _____

Phone _____

Hospital Preference (if any) _____

EMERGENCY CONTACTS: (after attempting to reach parents)

1st Contact _____ Phone _____

2nd Contact _____ Phone _____

HEALTH INSURANCE INFORMATION:

Company name _____

Company address: _____

Company phone: _____

Policy Number: _____

Policy Holder: _____



MEDICAL TREATMENT FORM



Child's Name _____

Date of last well visit _____

Please list any allergies (including foods, insect bites, medication, etc.):

Please list any long-term medications (and their purpose) your child is taking and possible side effects:

Please list any medical or behavioral condition(s) of which we should be aware:

IMMUNIZATION DATES:

DPT _____ _____ _____ _____

Polio _____ _____ _____ _____

HepB _____ _____ _____ _____

Hib _____ _____ _____ _____

MMR _____ Varicella _____ Pevnar _____
(or date child had
chicken pox)

Physician's Signature _____

Address _____

Date _____