

Child’s Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

List all allergies, including food allergies, and medical conditions we should know about:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IF PARENTS CANNOT BE REACHED, PLEASE CALL:

_____ (PHYSICIAN)	_____ (ADDRESS)	_____ (TELEPHONE NO.)
_____ (DENTIST)	_____ (ADDRESS)	_____ (TELEPHONE NO.)
_____ (FRIEND OR FAMILY MEMBER)	_____ (ADDRESS)	_____ (TELEPHONE NO.)
_____ (FRIEND OR FAMILY MEMBER)	_____ (ADDRESS)	_____ (TELEPHONE NO.)

Hospital Preference:

\_\_\_\_\_

In case of an emergency, I authorize the staff of Saint Andrews Preschool to provide and/or seek emergency medical care for my child.

Parent Signature: \_\_\_\_\_ Date \_\_\_\_\_