TRINITY PRESCHOOL
Emergency Contact/Medical Form

Student's Name: _____ Current Weight: _____

Birthday: _____ Teacher: _____ Grade: _____

Parent(s)/Guardian Name: _____

Street Address: _____ Email: _____

City/State/Zip: _____ Home Phone: _____

Daytime phone (Mother): _____ Daytime phone (Father): _____

Cell Number (Mother): _____ Cell Number (Father): _____

Emergency Contact/Pick-up Information other than parent/guardian (per NC DHHS, *must* provide at least two contacts):

Name/Relationship to child: _____ Phone: _____

Name/Relationship to child: _____ Phone: _____

Name/Relationship to child: _____ Phone: _____

MEDICAL INFORMATION

Is your child currently taking medications on a regular basis? _____ If so, please list medications; state why taking and possible side effects: _____

_____

Does this child have any allergies? _____ If so, please list: _____

Is this child currently under the care of a physician? _____ If so, please explain: _____

_____

Does this child have any other on-going health considerations? _____

_____

Physician's name: _____ Phone: _____

Dentist's name: _____ Phone: _____

Preferred Hospital: _____

Health Insurance Carrier: _____ Policy number: _____

In the event that I cannot be contacted, I hereby authorize Trinity Preschool to provide and/or seek emergency medical treatment for my child named above (including transportation to a medical facility, if needed). As a Parent or Legal Guardian, I understand that Trinity Preschool is not responsible for any expenses incurred because of an injury to my child or my child's illness. I give them permission to administer ice, band-aids and/or an antiseptic cleanser, if needed. Trinity Preschool does not administer prescriptions or over-the-counter medications without written parental consent. This statement is valid for the duration of the school year or until withdrawn by the parent in writing.

Signed: _____ Date: _____