

St. Paul Lutheran Preschool

2023-2024

Date: _____

Please be assured that all the Information you share on any of the Forms will be confidential. The information will provide us with information to determine if your family may qualify for scholarships, or any other financial help. We also use this information to get to know a little more about your child in order to provide them with the best education possible. Currently our licensing agency requires that **phone numbers AND addresses** be included for doctors, dentist, hospital, emergency contacts as well as for all those you designate as able to pick up your child from school.

A.M. session only:

Tues / Wed / Thurs / Fri. (Please Circle days you prefer)

Child's Name: _____

First

Middle

Last

Birth date: _____ Birth Weight: _____ Was your child Full Term: _____

Place of Birth: _____ Family Ethnicity: _____

Social Security: _____ Home Phone: _____

Address (Street and Mailing) _____

My child has the following allergies and / or medical needs:

Father's Name: _____ Age: _____ Phone _____

Home Address: _____ Occupation: _____

Dad's Highest level of education: _____

Wk Phone: _____ Wk Address: _____

Age of Dad when child was born: _____ Cell Phone # _____

Mom's Name: _____ Age: _____ Phone: _____

Home Address: _____ Occupation: _____

Mom's Highest Level of education: _____

Wk Phone: _____ Wk Address: _____

Age of Mom when Child was born: _____ Add'l Phone # _____

Address (Street and Mailing) _____

Family E-Mail-

Child's Doctor's **Name, Phone number and Address:**

Child's Dentist **Name, Phone Number, and Address:**

Preferred Hospital **Name, Phone number, and Address:**

Insurance information Include Group # and any information we might need to give emergency personal:

Contact person when student is ill and parents cannot be reached, but hospital or doctor is not necessary.

(Name, Phone Number, Address, Relationship) These people are also allowed to pick up my child at St. Paul Lutheran Preschool.

1st _____

2nd _____

3rd _____

- Did your child require any special medical and or / hospitalization at birth or during the first month of life?
- Does your child have any history of or current health concerns? (Please explain)
- Does your child have any opportunities to play with other children his or her own age and how often?
- Do you have any concerns with your child's growth and development? If yes please explain.
- Have you had any significant recent changes in your family such as (Separation, Divorce, Illness, Hospitalization, Homelessness, Frequent relocation, etc.)
- Is there any other additional information related to your family that puts stress on your family?
- Please list siblings in order of birth.

Total Household income for the last year: Please circle one

| | |
|---------------------|---------------------|
| \$10,000- or less | \$25,001- \$30,000 |
| \$10,001 - \$15,000 | \$30,001- \$35,000 |
| \$15,001-\$20,000 | \$35,001 - \$40,000 |
| \$20,001-\$25,000 | \$40,001 - above |

I, _____ give my child _____ permission to:

___ To view age appropriate videos. I do understand that the video will only be used for educational purpose and that I will be notified of the title.

___ To photograph my child throughout the year. These pictures will be displayed in the classroom, sent home and possibly used for Preschool Advertisements in the newspaper or online.

___ To allow the Newspaper to photograph my child. I understand that I will be informed as to when this happens.

___ To allow pictures of my child to be published online. I understand that I will be informed as to when this happens.

Signature

Date

Acceptance of Policies and Procedures:

I have read and understand all the information contained in the Preschool Handbook. I understand that if I have questions, comments or concerns I should contact the Preschool Director and work through the chain of command.

Signature

Date

EMERGENCY PROCEDURES

A. *TORNADOES* – In the event of a tornado, the children will be taken to the two door entrances facing hallway, sitting along the walls in a crouch and cover position until the all clear signal. We will conduct a tornado drill every other month.

B. *BLIZZARDS* – St. Paul Preschool follows Calhan School District RJ1 inclement weather closure policy. If Calhan District has a two hour delay or closes, St Paul Preschool will close. If a snow storm occurs during school hours the children will be kept warm and safe inside the building until their parents can safely get them.

C. *LOST CHILD* – the center would call 911 and provide information on the child and last where-about. Parents will be contacted immediately.

D. *FIRE* – We conduct a monthly fire drill. After the children are safely out of the building 911 will be called and parents will be notified immediately. The Fire Department will visit the children in the Fall.

E. *ACCIDENT/INJURY*- The staff of St. Paul Lutheran Preschool are all CPR, First Aid, and Universal Precautions qualified. The Director is qualified in Medical Administration. The following will occur in the case of an accident or injury:

1. Keep calm – notify Director immediately
2. If it is a serious injury or illness, call paramedics (911), then parents in that order.
3. There are emergency phone numbers posted next to the phone outside of the Bathroom and in the classroom.
4. Poison Control Center 1-800-332-3073 – Denver
5. Poison Control Center 1-800-332-3073 – Co. Springs

We also have our own *Emergency Response Guide and kit* in the classroom.

By signing this I approve of the St. Paul Lutheran Preschool Staff to provide Medical care for my child in the event of an emergency.

Signature

Date

GENERAL HEALTH APPRAISAL FOR ENROLLMENT IN CHILD CARE

(Completed by the Health Care Professional)

Child's name _____ Birthday _____

Health History & Medical Information pertinent to routine child care & emergencies:

_____ None

_____ Describe:

Special Diet _____

Allergies _____ Type of reaction _____

Current medications _____

Acetaminophen (Tylenol) in the amount of _____ may be given for fever over 102 degrees or pain every 4 hours as needed.

- *Note: No more than a 3 day period, without medical authorization.*

Describe any recurrent health problem (such as asthma, seizures, ear infections, diabetes, etc.) illness, hospitalization or concerns with development? _____ None

Comments: (include instructions to the child care provider(s)).

Date of most recent examination of child. (note: within the last 12 months) _____

Weight _____

Height _____

Vision _____

Hearing _____

Dental Screening _____

Immunizations given or attach immunization record: _____

_____ Date _____

Health Provider Name (printed)

Health Provider signature _____

Address _____ Telephone _____

I _____ give consent for my child's health care provider &
(Name of parent/legal guardian)
child care provider to discuss my child's health concerns.

Revised 4-4-2023 kmr