## Family and Social Background

This form will be shared with your child's teacher.

Members of household and their relationship to child:

_____

_____

Marital status of Parents: ☐married ☐single parent ☐separated ☐divorced
☐other:_____

Custody or visiting arrangements: _____

If child is adopted, age of adoption_____ Does your child know about it? _____

Does this child have any allergies (including allergies to medications)? _____

Describe your child's eating habits? Is a modified diet necessary?

_____

Provide information about your child's toileting habits: _____

Has your child previously attended a childcare center or daycare? _____

How long? _____ Was it a successful placement? _____
Comments:

Please list the names and telephone numbers of any persons authorized to take the child from school

Name: _____ Phone _____

Name: _____ Phone _____

Name: _____ Phone _____

Name: _____ Phone _____

Please list the persons to be contacted if a parent cannot be reached in an emergency or when there is an injury requiring medical attention

Name: _____ Phone _____
Address
_____

Name: _____ Phone _____
Address
_____

If your child have any emotional, behavioral, or medical concerns that we should be aware of please explain below.

Child's Schedule at school – please check the days/times your child will be at school:

- ☐ 5 Full Days – Monday/Tuesday/Wednesday/Thursday/Friday
- ☐ 3 Full Days – Monday/Wednesday/Friday
- ☐ 2 Full Days – Tuesday/Thursday

- ☐ After-School care (3:05-5:45pm)

_____ _____
Parent/Guardian Signature Date

## Non-Prescribed Medication Authorization

The following non-prescribed items: diapering products, sunscreen lotions, teething gel and insect repellants will be given with parental permission and according to manufacturer's instructions unless there are written instructions provided by a licensed physician or dentist.

*The following is by Director Exception only:* Child will be given prescribed or non-prescribed oral or surface medication with physician permission. Medication must be in its original container and have a legible label with the child's name and current prescription information. Non-prescribed items (cold medicine or Tylenol) not mentioned above must be accompanied by a doctors note. The administration of medication is recorded and the record is approved by the child's parent. Any expired or unused portion will be returned to the child's parent or destroyed.

I hereby authorize the staff of St. Mary's School to administer the checked below listed medications. I understand that no other prescribed or non-prescribed medications will be given without physician's written permission.

_____ Teething Gel (oral gel)
_____ Sunscreen Lotions
_____ Diapering Products
_____ Insect Spray

Signature of parent or guardian Date

## Field Trip Authorization

I hereby give my permission for my child to go on impromptu walking field trips in the neighborhood. This includes walks around the blocks in the adjoining neighborhood. I understand that I will be notified of field trips for farther distances through a written permission form.

Signature of parent or guardian Date

## Parent Handbook and Program Plan

By signing this form you are acknowledging that you have received, read, had an opportunity to ask questions, understand, and agree to abide by our Parent Handbook and Program Plan.

Signature of parent or guardian Date

## Emergency Authorization

I authorize St. Mary's School to act on my behalf in the case of an emergency and provide emergency care and treatment.

Signature of parent or guardian Date

## Health Care Summary

Completed by a health care provider

Date of Enrollment: _____

NAME OF CHILD _____ Birth Date _____

ADDRESS _____ Telephone _____

PARENT(S) OR GUARDIAN _____

Date of last physical examination _____
How long have you been seeing this child? _____

How frequently do you see this child when he/she is not ill? _____

Does this child have any allergies (including allergies to medications)? _____

Is a modified diet necessary? _____

Is any condition present that might result in an emergency?
_____
_____

What is the status of the child's Vision _____
Hearing _____
Speech _____

Please list below the important health problems

| Important Health Problems | Followed By You | Followed By Other Med Source (Name) | Requires Special Attention at School |
|---|---|---|---|
| | | | |
| | | | |

Other information helpful to the school:
_____

_____

Child's source of regular medical care:

Name: _____ Phone _____

Address: _____

Dental Care:

Name: _____ Phone _____

Address: _____

Emergency Medical Care:

Name: _____ Phone _____

Address: _____

Emergency Dental Care:

Name: _____ Phone _____

Address: _____

**Signature of Health Source** _____ **Date** _____