PARENT INFORMATION FORM

Child's name: ____________________

Birth date:______________________

Nickname:______________________

Mother's Name:___________________

Occupation:_____________________

Work #:_________________________

Cell #: ________________________

Business Address:_________________

Doctor's Name:____________________

Doctor's #: _______________________

Address: ___________________________
____

Telephone #: _______________________

Email: _____________________________

Father's name:______________________

Occupation:_________________________

Work#:_____________________________

Cell #: ___________________________

Business Address:___________________

Siblings:______________ Age:________

______________ Age:________

Name and phone number of Emergency contact ____

____

Does your child have any allergies or medical conditions? If so please explain

____

Has your child participated in group programs before? If so, which ones? Were there any separation issues?

____

I understand that my child will NOT be napping during school hours.

Signed____Date:_________________

PICK UP AUTHORIZATION

Please list the contact information of any person you are authorizing to pick your child up from school. If they are not on the list, we cannot release your child to them. If you are having your child picked up by a new person not on this list please provide a photo of them and contact information via email before pick up.

People that may pick up my child:

1-________________________________ Phone #:_________________________

2-________________________________ Phone #:_________________________

3-________________________________ Phone #:_________________________

Parent Signature:________________________ Date:____________________

MEDICAL FORM

Childs Last Name ________________ M F Date of Exam________________

First Name ________________

Date of Birth ________________ Exam: Normal Abnormal

Vision ________________ Hearing ___________________

Height ________________ BP ___________________

Weight ________________ Pulse ___________________

Scoliosis Yes No Urine ___________________

Gym Yes No HGB ___________________

Allergies ____

Medications ____

Restrictions ____

Comments ____

____

MD's Signature_________________________________ Date________________________

Vaccination	Date	Date	Date	Date	Date	Date	Date
Polio							
DTP/Dtap							
MMR							
Hib							
Hepatitis B							
Varicella							
Pneu							
Flu Vaccine							
Other							
Screening							
Tuberculin/PPD							
Lead							

IN CASE OF MEDICAL EMERGENCY

I give written permission to The Church in the Highlands ECC staff to obtain medical care for my child if he/she develops symptoms of illness or is injured while at the school.

If there is a serious emergency we will call 9-1-1 and contact you immediately. We will take your child by ambulance to the nearest Hospital Emergency Room, and contact you to meet us there.

I also give permission to clean and apply an antibiotic ointment for minor scrapes and bruises if necessary.

Child's Name: ____________________________ Signature of Parent or Guardian:_____________________________

Class: ___________________________________ Date: ____________________________

PHOTO EXCLUSION & EMAIL POLICY FORM

Dear Parents,
As you may know our school has a website that we often update to better communicate with parents and to promote our program. We would also like to use these pages to feature our students participating in a variety of activities designed to enhance their learning and to highlight and celebrate their achievements.
We realize that posting student photos on the website is a serious responsibility. The Church in the Highlands has made a decision that photos of students posted to our site will not show any names. In addition, photographs and videos are taken throughout the school year in classes and other activities. These may become public or be used in publications, such as school fliers or pamphlets. Please check the appropriate box and return to your child's teacher. We thank you in advance for your attention to this matter.

☐ I do not want my child's photo and or video published on the website of the Church in the Highlands or the Church in the Highlands ECC Facebook page.

☐ I give permission to have my child's photo and or video on the Church in the Highlands ECC website or Facebook page. It is my understanding that my child's name will not be associated with the photo.

☐ I give permission to have my phone number, home address and email address included in the class list which is distributed to the parents and staff.

Child's Name:_________________________ Parent's Name:____________________________

Child's Teacher:_____________________ Parent's Signature:_________________________

DENTAL FORM

Dear Parents:

As you know, our Early Childhood Center is licensed through the New York State Office of Children and Family Services. As part of the regulations we need to provide certain information, including information that pertains to your child's last dental check-up. If your child has not been to the dentist yet please provide us with the name of your family dentist. Take a moment to complete this form and return to the office by the first day of school.

Child's Name: ______________________________

Date of Birth: ______________________________

Current Classroom: __________________________

Date of most recent Dental Exam and Cleaning:____

Name of Dentist: ____

Parent/Guardian Signature: _______________________________________Date _____________