The Children's Center Preschool Broomfield, CO

PRESCHOOL EMERGENCY AND MEDICAL RELEASE FORM

Student's Name: ____School Year: _______

Please number guardian and emergency contact in order of preference your desired call order in the case of illness or injury. **One of the below must be available to pick up child if he/she has to go home.**

(   ) **Parent/Guardian #1 Name**: ____

Cell Phone: _________________________________ Home Phone: _____________________________

Home Address: ____

Work Phone: _________________________________ Email: _________________________________

Employer: ____

Employer Address: ____

(   ) **Parent/Guardian #2 Name**: ____

Cell Phone: _________________________________ Home Phone: _____________________________

Home Address: ____

Work Phone: _________________________________ Email: _________________________________

Employer: ____

Employer Address: ____

Student Lives with ___ Both Parents ___Parent#1 ___Parent#2 ___Guardian ___ Foster Home

(   ) **Emergency Contact Person#1**____

Cell Phone: _________________________________ Home Phone: _____________________________

Home Address: ____

(   ) **Emergency Contact Person#2**____

Cell Phone: _________________________________ Home Phone: _____________________________

Home Address: ____

Medical Personnel to be contacted in case of emergency:

Physician Name: ________________________________ Phone Number: __________________________

Address/Zip: ____

Dentist Name: ________________________________ Phone Number: __________________________

Address/Zip: ____

Please **circle** your choice of hospital for your child to be transported in a medical emergency:

Children's Hospital   St. Anthony's North   Other_____________________

469 State Highway 7   14300 Orchard Pkwy   _________________________

720.777.1340   720.627.0000   _________________________

Medical Insurance Provider: ____

Policy Number: ____

Member Name: ____

Hospital of Choice: ____________________________Street Address: ______________________________

Phone Number:______________________________

Does this child have food allergies: YES NO If yes, please specify: ________________________________

Does this child have drug allergies: YES NO If yes, please specify ________________________________

Is an Epi-Pen required/Prescribed by a doctor: YES NO

Does this child have asthma? YES NO

If yes, list triggers: ______________________________________Has an inhaler been prescribed by a doctor? YES NO

Does this child have any other medical conditions/illnesses? YES NO

If yes, please specify: ____

Please list any important information to help us better care for your child while at school:

____

Please list any daily medications your child takes at home (including vitamins):

____

I understand that I am responsible for applying sunscreen to my child each day. My child will be playing outside for 30 minutes each day when weather allows. **Please Initial** _______________

I authorize for my child's photo to be taken for *classroom purposes only*. Pictures will **not** be used for marketing or advertising purposes. **Please Initial** _____________

*All medications given at school MUST be provided by the parents and MUST have a DOCTOR'S ORDER (school forms)

AUTHORIZATION

- Each year the school nurse prepares a confidential list that includes students who have significant health concerns. This confidential list is shared with staff for the sole purpose of protecting the health and well-being of the student. By signing below you allow the nurse to share any information deemed appropriate.
- In the event of an emergency and if all efforts to reach me have been unsuccessful, I give authorization for my child to be taken to the nearest emergency room and to be treated there by my doctor or his/her substitute. I understand that this authorization will accompany my child and that efforts will continue to be made to reach me. I further agree to assume all financial obligations incurred.

Parent/Legal Guardian Signature: ____Date:_______________