

**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 contacts below must be available to pick up child within 20 mins if they need 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: \_\_\_\_\_

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: \_\_\_\_\_

Special instructions for reaching parents and emergency contacts during school hours: \_\_\_\_\_

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: \_\_\_\_\_