FIRST UNITED METHODIST CHURCH PRESCHOOL PROGRAM

Child's name _____Birthdate _____

Parent's names(Mom) _____Phone (home)_____
(work)_____
(Dad)_____ Phone (home)
(work)_____
(Cell Phones) _____Mom's
Dad's_____
Family email address_____

Address _____
(street) (city) (zip)

Names & phone numbers of friends and/or relatives authorized to pick up my child (You must list at least two persons besides the child's parents, in case of an emergency. These are the only people your child will be released to):

(name) (phone)

(name) (phone)

Your Child

Does your child have any **FOOD ALLERGIES?**

Is child potty trained? _____ Any toilet hints? _____

Is play restricted in any way? _____ Please explain _____

In what way can we be of most help to your child while he/she is under our care and guidance?

Emergency Medical Treatment

Unless otherwise notified, the staff of the FUMC Preschool Program will administer first aid for bumps, bruises, cuts, scratches, splinters, or nose bleeds.

Consent for Medical Treatment

In the event that a more serious illness or injury occurs, the FUMC Preschool Program Director will make every attempt to contact one of the parents listed above. If we are unable to reach either parent, this form will allow the minor to be treated promptly by a licensed physician or dentist.

Family Physician: _____(Phone)_____

Dentist: _____(Phone) _____

If hospital treatment is necessary, I/We prefer that my child be taken to _____

Hospital at_____

I consider the information listed below as something that should be known in determining the proper treatment to be given to the above listed minor: (attach a current copy of your child's immunization record with this registration form)

Last tetanus immunization:_____

Allergies (be specific)_____

Medication being taken:_____

Physical impairments:_____

Other facts that you deem necessary:

I/We authorize the FUMC Preschool Program Director to secure EMERGENCY medical care for my child when I/we cannot be immediately reached at the time of the emergency. I/We will be responsible for the emergency medical charges upon receipt of the statement.

(date)_____(signature)_____ (relationship to child)_____