



SonShine Preschool Student Information Form

Please Print below using black or blue ink.

Name of Student:	
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Date of Birth	Sex	Age	Home Church:
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Name of Parent/Guardian:	
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Address:		E-mail address:
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Home Phone:		Cell Phone:	
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Emergency Contact:	Name	Relationship to Child
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Address	Phone	Cell Phone
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Medical History & Release:	Please fill out as completely as possible.	Preferred Hospital
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Physician Name	Physician Address:
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Physician Phone	Insurance Carrier and Policy Number
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Part 1: Medical Conditions: Check those that apply and give dates

Diseases: <input type="checkbox"/> Chicken Pox _____ <input type="checkbox"/> Measles _____ <input type="checkbox"/> German Measles _____ <input type="checkbox"/> Mumps _____ <input type="checkbox"/> Other (specify) _____ _____	Allergies: (specify) <input type="checkbox"/> Animals _____ <input type="checkbox"/> Food _____ <input type="checkbox"/> Plants/Pollen _____ <input type="checkbox"/> Insect Stings _____ <input type="checkbox"/> Medicine _____ <input type="checkbox"/> Other _____	Chronic/Recurring Illnesses: (describe) <input type="checkbox"/> Ear Infections _____ <input type="checkbox"/> Heart Defect/Disease _____ <input type="checkbox"/> Seizures _____ <input type="checkbox"/> Bleeding Disorders _____ <input type="checkbox"/> Asthma _____ <input type="checkbox"/> Diabetes _____
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Part 2: Other Conditions: Please explain any items that are checked

<input type="checkbox"/> Restricted Activity <input type="checkbox"/> Constipation <input type="checkbox"/> Motion Sickness <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Mental Health Issues	<input type="checkbox"/> Fainting <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Special Diet <input type="checkbox"/> Corrective Lenses <input type="checkbox"/> Other	Date of last exam: _____ Surgeries/Hospitalizations: _____ Medications currently taking: _____ Describe any checked: _____ _____
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This health history is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me and/or the prescribing physician. In case of illness or injury, I/we give permission for him/her to receive first aid, and to received emergency treatment from a licensed physician and/or hospital with the most reasonable access. I/we further release SonShine Preschool and Calvary Lutheran Church from any liability or damages, including any claim for injuries incurred by my/our child as a result in participation of programs.

Signature of Parent(s)/Guardian _____ / _____ Date _____



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Your Child: Please help us to understand your child so that we may tailor the program to his/her needs.

Does your child have any significant physical or emotional condition? **YES** **NO**

If yes, please describe: _____

Does your child have any fears/phobias that we should be aware of? **YES** **NO**

If yes, please describe: _____

Does your child have an imaginary playmate? **YES** **NO**

If yes, please describe: _____

Does your child play with other children? **YES** **NO**

If yes, what are the sex and ages of their most frequent companions? _____

Does your child usually play alone? **YES** **NO**

Do you or someone else regularly read to your child? **YES** **NO**

If yes, what are his/her favorite books: _____

What activities does your child enjoy doing with ...

Mother? _____

Father? _____

Siblings? _____

Grandparents? _____

What type of play would you describe as being your child's favorite? _____

Does your child have a regular nap and/or bedtime? **YES** **NO**

Anything we should know about his/her sleep habits?: _____

YES **NO**

Do you wish to participate in our class phone list? **YES** **NO**

Equal Opportunity Information: This information is needed to insure equal educational opportunities for your child and may not be used to discriminate against him/her. This information is also required to file state and federal report. Please check the appropriate category.

White

Hispanic

Russian

African American

American Indian/Alaskan Native

Asian /Pacific Islander

I (print parent's name) _____ understand that SonShine Preschool / Calvary Lutheran Church's insurance shall be excess over any other valid and collectible insurance to the injured person. This is subject to the insurance company's limit of liability for medical payments.

Parent Signature: _____ Date: _____