CONFIDENTIAL

Personal Student Information

Child's Full Name ______________________________

Nickname__________________DOB_________ Male or Female

Home Address ______________________________

Email______________________ (Preferred/ primary emai used for communications relating to school activities / announcements)

Parent or Guardian /Relationship to Student: (Check): Mother , Stepmother ,*Father* , *Stepfather* , *Guardian* , *Coparent* , *Other*

First Name ____________________ *Last Name* ____________________

Business Address ______________________________

Email Address ____________________Cell Phone ____________________

Parent or Guardian /Relationship to Student: (Check): Mother , Stepmother ,Father , Stepfather , Guardian , Coparent , Other

First Name ____________________ *Last Name* ____________________

Business Address ______________________________

Email Address ____________________Cell Phone ____________________

Primary Phone Number to be used in an emergency or if I child is sick, this number will be entered into school's cell phone, which is always with the teachers.
Primary number

____

Secondary Number (Optional)

____

Parents Marital Status (Check): *Married , Partners , Widowed , Divorced , Separated , Single*
Are there any custodial issues (court papers) regarding your child YES or NO (If yes, please attach Custodial Papers.)

Siblings: Name____________________ Age _______ Name ____________________ Age _______
Name ____________________ Age _______ Name ____________________ Age _______

Child's Physician____________________Phone ____________________
Allergies? Yes/No. If Yes, Explain____________________Epipen? YES________ OR NO______
Routine Medications? Yes/No. If Yes, Explain ____________________
Other concerns/issues if any:____________________

Early Intervention or CPSE: OT/PT/Speech Therapy/Special Instruction
Any special requests or comments that the class/teacher should know: ____________________
____

Person(s) to notify if parents cannot be reached in an emergency:
Name____________________Phone ____________________
Address ______________________________

Name____________________Phone ____________________
Address ______________________________

Person(s) responsible for transporting child to and from school:
Name____________________Phone ____________________
Name____________________Phone ____________________

Sharing of information: Your name, phone, and email will be shared with other members of the corporation for preschool-related purposes. Please check if you wish to have this information shared:
____ Yes ____ No

Photo Release: We will occasionally take pictures of your child which could be displayed on our school website and/or in the local paper(s). Please check if you wish to have pictures published in this manner:
____ Yes ____No

In the event that IMMEDIATE medical attention is necessary, I give permission to the teaching staff of Maple Hill Preschool, who have completed a certified CPR/First Aid course, to obtain, and/or provide emergency medical treatment to my child. In the event that routine medical services are needed, the teacher will notify the parent first (unless otherwise noted above). If the event is an emergency (potentially life-threatening) the teacher's first responsibility will be ensuring that the child is provided for.

______________________________ ____________________
Parent(s) or Guardian(s) Signature Date

Castleton Volunteer Ambulance Service

Medical Information Record

The purpose of this **Medical Record** is to assist the emergency & ambulance personnel. This record provides us with a quick medical history and other information necessary to better serve you.

Please take this time to fill out the following information. Thank you for your cooperation in helping us, help you.

CASTLETON AMBULANCE EMERGENCY # 911
POISON CONTROL # 1-800-222-1222

NAME: ________________________________ D.O.B. ______________________

ADDRESS: ____

PARENTS: ____

HOME # ______________ WORK # ______________ CELL # ______________

PHYSICIAN: ______________________ PHYSN. PHONE # _________________

PREFERRED HOSPITAL FOR TREATMENT: _____________________________

PAST MEDICAL HISTORY (EX: ASTHMA, DIABETES, STROKE, C.O.P.D. ETC.)

____

____

ALLERGIES/INTOLERANCES:____

CURRENT MEDICATIONS: ____

____

____

INSURANCE CARRIER: _________________

DENTAL/OTHER COVERAGE: ______________

CONFIDENTIAL

CERTIFICATE OF IMMUNIZATION AND HEALTH RECORD

(TO BE COMPLETED AND SIGNED BY CHILD'S PHYSICAN)

Child's Name:____ Birth Date:_______________

Immunization History: (Date Received)

Polio	**1________**	**DTaP**	**1_________**	**HIB**	**1________**	**Hep B**	**1________**
	2________		**2_________**		**2________**		**2________**
	3________		**3_________**		**3________**		**3________**
Varicella	**1_________**	**MMR**	**1__________**				

PCV 1_________ 2_________ 3_________ 4_________

Medical History:

Chicken Pox ____________ Asthma _______________ Heart Trouble ______________

Seizures ________________ Scarlet Fever __________ Bladder/Bowel ______________

Diabetes _______________ Kidney _______________

Allergies/Intolerances (specify): ____
____

Other:____

Routine Medications? Yes_______ No___________ If yes, explain____________________
____

Is there any medical reason the child's activity at the Preschool should be limited?
Yes________ No_________ If Yes 'explain____

What is the general condition of the child's health?____________________________________

Date the child was last examined by a Physician_____________________________________

Dated_________________ Physician's Signature_______________________________________

Student Snapshot

The information provided in the forms will be utilized by the teachers, to get a jump-start in getting to know the student's ahead of time. Additionally, we can leverage the information to enhance or adjust lessons planned throughout the year, which helps ensure a fun adventure for each student at Maple Hill Preschool.

Name: ___________________________________ **Nickname:** __________________________________

1. **Please include a labeled family photo or drawing of your family**
2. **Likes: (examples: superheros, characters, music, art, toys, activites, etc.)**
    -
    -
    -
3. **Dislikes: (examples: loud noises, tastes, textures, etc.)**
    -
    -
    -
4. **Favorite Book-** ____
5. **Favorite food and drink: (examples: prefers milk or water, fruit or vegetables, etc.)**
    -
    -
    -
6. **What would they like to learn about? (examples: colors, bugs, fish, music, dinosaurs)**
    -
    -
    -

7. **How does your child respond to the following?**
    - **Transitioning from one activity to another: ____**
      ____
      ____
    - **Separation from parents or caregivers: ____**
      ____
      ____

8. **What helps your child relax, if/when they are anxious about something?**
   ____
   ____
   ____

9. **How does your child interact with others in a group setting? (examples: play dates, story hour, do they tend to be more introverted or extroverted, etc.)**
   ____
   ____
   ____

10. **Anything special you or your child would like the teachers to know or be aware of?**
    ____
    ____
    ____

11. **Please use the following space to write, draw or paste something that is currently significant to your child.**
    ____
    ____
    ____

PLEASE NOTE: We know things may change over the summer and even throughout the school year.
Feel free to update the teachers in person about any changes in your child's life.