

VPC Preschool Emergency Contact and Medical Information 2018-2019

Male _____
Female _____

Child's Name (Last, First/Preferred Name) _____

Date of Birth _____

Mother's Name (Last, First) _____

Father's Name (Last, First) _____

() _____
Home Phone

() _____
Work or Cell Phone

() _____
Home Phone

() _____
Work or Cell Phone

Street Address _____

Street Address _____

City, State, Zip Code _____

City, State, Zip Code _____

Email _____

Email _____

Alternative Emergency Contacts – If Parents Cannot be Reached

Primary Emergency Contact (Last, First) _____

Secondary Emergency Contact (Last, First) _____

() _____
Home Phone

() _____
Work / Cell Phone

() _____
Home Phone

() _____
Work / Cell Phone

Relationship _____

Relationship _____

Persons Authorized to Pick Up your Child on a Continuing Basis

Name _____

Phone _____

Relationship to Child _____

Name _____

Phone _____

Relationship to Child _____

Name _____

Phone _____

Relationship to Child _____

Please list anyone you do not want to pick up your child:

Name _____

Relationship to Child _____

Medical and Educational Information

Allergies/ Special Health Considerations:

Does your child receive special education services? Yes/No If yes, date of the IEP : _____
Please provide preschool with a copy of the IEP so we may best support your child.

Parent Signature _____

Date _____

