ST. MATTHEW'S PRESCHOOL
EMERGENCY CONTACT/ PARENTAL CONSENT FORM

CHILD'S NAME _____ BIRTHDATE _____

ADDRESS _____

MOTHER'S NAME _____ HOME PHONE _____

ADDRESS _____

WORK PLACE _____ WORK PHONE _____

FATHER'S NAME _____ HOME PHONE _____

ADDRESS _____

WORK PLACE _____ WORK PHONE _____

EMAIL ADDRESS_____

EMERGENCY CONTACT PERSON(S)

NAME _____ PHONE# _____

NAME _____ PHONE# _____

NAME _____ PHONE# _____

PERSON(S) TO WHOM CHILD MAY BE RELEASED

NAME _____ PHONE# _____

NAME _____ PHONE# _____

NAME _____ PHONE# _____

NAME _____ PHONE# _____

CHILD'S PHYSICIAN _____ PHONE# _____

CHILD'S SPECIAL NEEDS _____

_____

ALLERGIES (INCLUDING MEDICATION REACTIONS) _____

_____

MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION _____

_____

A PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE CONSENT:

ADMINISTRATION OF MINOR FIRST AID_____
(band-aids, ice packs, Neosporin)

OBTAINING EMERGENCY MEDICAL CARE _____

PHOTOS OF MY CHILD TO BE USED FOR MEDIA BROADCAST, INCLUDING NEWS SEGMENTS, NEWSPAPER ARTICLES AND OUR PRESCHOOL WEBSITE & FACEBOOK PAGE
(no names will be posted with website/Facebook photos)

_____

CONSENT TO TRANSFER INFORMATION TO YOUR CHILD'S ELEMENTARY SCHOOL
_____

I GIVE PERMISSION TO ST. MATTHEW'S PRESCHOOL TO DISCLOSE THE ABOVE INFORMATION TO ALL PRESCHOOL STAFF ON A NEED TO KNOW BASIS.

_____ _____
PARENT SIGNATURE DATE