ENROLLMENT & EMERGENCY INFORMATION FORM
Southern Oregon ESD – Early Childhood Services

Child's Name:	**Date of Birth**:
Parents' Names:	**Home Phone**:
Address:	**Work/Cell Phone**:
Siblings - Names & Ages:	
Child's Doctor:	**Doctor Phone Number**:

List two names and phone numbers of people we may contact in an emergency if we are unable to contact you:

Name: Phone: Relationship:

Name: Phone: Relationship:

In case of an emergency I authorize the program listed above to:

Call an ambulance:_____ yes _____no Provide first aid:_____ yes _____no
Transport to Three Rivers Community Hospital: _____yes ____no
Contact attending physician if child's doctor is not available: _____ yes ____no

I authorize the following people to pick up my child/children at the program listed above. If there are any changes, I will let the school know in writing in advance.

Name: Phone: Relationship:

Name: Phone: Relationship:

Name: Phone: Relationship:

Note: If there are any special instructions or any persons who are <u>not</u> authorized to pick up your child, please list here (we will require I.D. from anyone new that picks up your child):

Communication between school and home:
We can email to you monthly newsletters, announcements, holiday reminders, etc. Please complete the following if you would like information emailed rather than on paper in your child's cubby! Look for emails from **Early Childhood Services** .

EMAIL ADDRESS: ____ (Please Print CLEARLY ☺)

Please complete other side

Is your child presently taking medication?__________ If yes, please complete the following:

Medication: Dosage (amount) Frequency (time of day)

Does he/she need to take the medication at school?

Does your child have any food allergies?___________ If yes, please list:

What are your child's food preferences?

Does your child have difficulty chewing and/or swallowing?________ If yes, please describe

Does your child have any other allergies (e.g.-medicine, etc.)?__________ If yes, please list:

Does your child have any other restrictions (medical or otherwise?)?__________ If yes, please list:

Does your child have seizures?__________ If yes, please describe:

Are seizures controlled by medication?

If your child covered by medical insurance?_________ If yes, please describe:

Has your child had any other school or childcare experiences (toddler group, play group, preschool, etc.)?

Does your child have a favorite thing that comforts him or her (toy, blanket, etc.)?

What words do you use for the toilet and elimination?

Is there any additional information of which you feel we should be aware?

I certify that the information here is as complete and accurate as possible, and that if any changes occur I will notify the staff immediately.

____

Signature of Parent/Guardian Date