



Student Registration 2012 – 2013 p.2

Mother: _____

Home address (if different from child's): _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Work Days & Hours: _____

Church Affiliation: _____

Father: _____

Home address (if different from child's): _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Work Days & Hours: _____

Church Affiliation: _____

Sibling Names	Birth date	School Attending
_____	_____	_____
_____	_____	_____
_____	_____	_____

Farragut Church of Christ Preschool

Student Health History

Child's Name	Birth date	Parent/Legal Guardian Name
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The information on this form is gathered to assist us in identifying appropriate care should the need arise. Please provide complete information so that staff will be aware of your child's needs.

- | | | |
|---|---|--|
| Y | N | 1. Were there any problems with pregnancy or your child's birth? |
| Y | N | 2. Was your child born prematurely? |
| Y | N | 3. Is your child taking any medications on regular basis?
If yes, what medication: _____
For what: _____ |
| Y | N | 4. Does your child have any allergies (food, medicine, insects, shots, etc.)?
If yes, what kind and symptoms: _____ |
| Y | N | 5. Has your child had asthma or wheezing? |
| Y | N | 6. Is there any hearing or speech problems? |
| Y | N | 7. In the last year, has your child had 2 or more ear infections? |
| Y | N | 8. Has your child had trouble with his/her eyes or vision? |
| Y | N | 9. Does your child have tubes in his/her ears(s)? |
| Y | N | 10. Has your child had any kidney or bladder infections? |
| Y | N | 11. Has your child had seizures, fits, or shaking spells? |
| Y | N | 12. Is your child a hemophiliac (free bleeder)? |
| Y | N | 13. Has your child ever had a reaction to the TB skin test? |
| Y | N | 14. Does your child have any chronic rashes or skin conditions? |
| Y | N | 15. Does your child have any unusual birthmarks? |
| Y | N | 16. Does your child have any health issues not indicated above? |

Farragut Church of Christ Preschool

Emergency Information

Name of local person, other than teacher, authorized to act for parents in an emergency.

Name: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Work/School Address: _____

Work Phone: _____ Work Days & Hours: _____

Child's Physician:

Name: _____ Phone: _____

Address: _____

Hospital Preference: _____

Child's Dentist: Name: _____ Phone: _____

In addition to parents, the following persons have the permission to pick up my child

Name: _____ Relationship: _____

Daytime Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Daytime Phone: _____ Cell Phone: _____

I hereby authorize the Farragut Church of Christ Preschool to secure emergency medical treatment on my child's behalf. I hold harmless staff of the Preschool in connection with any emergency treatment rendered. I understand every attempt will be made to contact me incase of an emergency.

Parent/Legal Guardian Signature

Date