San Marcos Lutheran Church
Children's Center
3419 Grand Avenue
San Marcos CA 92078
Ph 760-727-0326 www.smlcchild@sbcglobal.net

IDENTIFICATION AND EMERGENCY INFORMATION

2016-17

Child's Name: ____ **Date of Birth:** ___________
(Last) (First) (M.I.)

Child's Home Address: ____
(Street) (City) (Zip)

E-Mail: ____

Mother's/Guardian's Name: ________________________________ **Home Telephone:** ____________

Mother's Home Address (if different from above) ____

Place of Employment: ___________________________ **Work Phone:** _____________ **Cell:** __________

Father's/Guardian's Name: ________________________________ **Home Telephone:** ____________

Father's Home Address (if different from above) ____

Place of Employment: ___________________________ **Work Phone:** _____________ **Cell:** __________

Please share my name and e-mail in the Parent Directory: **Yes** __________ **No** __________

Please share my phone number with other parents upon request: **Yes** __________ **No** __________

Names of additional persons authorized to take child from the preschool: (They will need to show identification)

Name: ______________________________ Relationship to child: _____________ Phone: ___________

Name: ______________________________ Relationship to child: _____________ Phone: ___________

Name: ______________________________ Relationship to child: _____________ Phone: ___________

Name: ______________________________ Relationship to child: _____________ Phone: ___________

Name: ______________________________ Relationship to child: _____________ Phone: ___________

Name: ______________________________ Relationship to child: _____________ Phone: ___________

In the event of a regional emergency, please list a person we can contact who lives out of the area (preferably out of state):

Name: ___________________________ City, State: _________________ Phone: ____________________

Physician or dentist to be called in an emergency:

Physician Name:____ Office Phone: _______________

Address: ____ Medical Plan: ______________________

Dentist Name: ________________________ Phone: _______________ Address: __________________

Please fill out the information on the other side of this sheet!

Permission to Receive Medical Care

I hereby authorize San Marcos Lutheran Church Children's Center to contact the above named medical or dental personnel regarding medical or dental treatment in the event of an emergency in which neither parent can be reached. I also authorize the emergency transportation and subsequent medical treatment of my child.

Parent or Legal Guardian Signature Date

Medical Information

Please list known allergies:

1 ______________________________ Usual reaction: ______________________________

2 ______________________________ Usual reaction: ______________________________

3 ______________________________ Usual reaction: ______________________________

Please list current or ongoing medical conditions experienced by your child:

Has your child had any type of surgery? If yes, please explain:

Please list medications your child takes on a regular basis:

Please list any physical conditions that may limit your child's participation in regular classroom or outdoor activities:

Does your child have on file a physician's exemption from any immunizations? Yes or No

Please list any additional medical information that the preschool or medical personnel would need to be aware of in case of emergency:

San Marcos Lutheran Church Children's Center 3419 Grand Avenue, San Marcos 92078 (760-727-0326)