Los Altos Grace Preschool * 6565 Stearns Street * Long Beach, CA 90815 * (562) 430-6813

ENROLLMENT & EMERGENCY CONTACT INFORMATION

STUDENT'S LAST NAME FIRST MIDDLE Date of Birth

( )
Address (Street) Apt. # City Zip Home Telephone Number

☐ Father
☐ Stepfather
☐ Guardian
☐ Not in Home

Name Occupation

Cell Phone: ( )

Name of Employer Work Telephone (w/extension)

☐ Mother
☐ Stepmother
☐ Guardian
☐ Not in Home

Name Occupation

Cell Phone: ( )

Name of Employer Work Telephone (w/extension)

Out of State Disaster Contact:

( )
Name Phone #

EMERGENCY CONTACT INFORMATION
EMERGENCY NUMBERS – MUST BE COMPLETED
and only the people listed on this form will be permitted to pick up your child in the event of an emergency (earthquake, natural disaster, etc.), illness or injury. Any other persons must have written authorization from parent or guardian.

PERSON RESPONSIBLE FOR CHILD: ______

Please list EMERGENCY contacts name, telephone number, and relationship in the order you wish them to be called.

NAME	ADDRESS	TELEPHONE (with area code)	RELATIONSHIP

ADDITIONAL CONTACT INFORMATION

Names of additional persons authorized to take my child from the facility on a regular basis (i.e. carpools):

NAME	TELEPHONE (with area code)	RELATIONSHIP

Please name specific person(s) who may NOT take child away from school. If this person is the child's parent, a restraining order must be on file in the school office. ______

For Office Use Only:____ Date enrolled:______ Date left:______

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AUTHORIZATION FOR EMERGENCY CARE

Child's Name: ______________________________ Date of Birth: ____________________

Address: ______________________________ Phone: ______________________________

City: ____ Zip: ______________

Initial

[ ] I hereby authorize Los Altos Grace Schools to call an emergency ambulance in case of accident or acute illness, and to arrange for necessary emergency medical and surgical care, in case I am not immediately available. Any qualified physician called by Los Altos Grace Schools may treat and do whatever is necessary for the health and well-being of my child. It is understood that a conscientious effort must be made to notify us (parents) before such action will be taken. I also agree to accept responsibility for the cost of above medical services not covered by school insurance.

Doctors Name: ____________________ Address____________________ Phone # (___) __________

Name of Medical Insurance ______________________________ ID Number ____________________

Dentist Name: ____________________ Address ____________________ Phone # (___) __________

Dental Insurance ______________________________ ID Number ____________________

Does your child have any special/serious health problems? Yes ☐ No ☐ If yes, please explain:

____

Allergies to food: Yes ☐ No ☐ If yes, please list: ______________________________

Allergies to environment: Yes ☐ No ☐ If yes, please list: ______________________________

Allergies to medication: Yes ☐ No ☐ If yes, please list: ______________________________

Name of Current Medications ____

Will your child be taking medication(s) at school? Yes ☐ No ☐ If yes, please list ____________________

____

A "Parent Consent for Administration of Medications" form must be on file in order for a medication to be administered at school.

Signatures: This form must have two signatures.

MOTHER/LEGAL GUARDIAN ____ Date __________

FATHER/LEGAL GUARDIAN ____ Date __________

It is our usual practice to release children to either parent. If, through custody, guardianship, or some other arrangement that places a restriction on one or both parent's ability to pick up their child from school, please provide the office with appropriate documentation of such arrangement.