

**Emergency Contact and Medical Information
for Preschool in the Valley at Great Valley Pres. Church**

Child's full Name _____		Date of Birth _____	M F Sex
Mother's/Guardian's Name _____		Father's/Guardian's Name _____	
() _____ Home Phone	() _____ Cell-Phone	() _____ Home Phone	() _____ Cell-Phone
Address _____		Address _____	
City, ST ZIP Code _____		City, ST ZIP Code _____	
Employer _____		Employer _____	
Family e-mail address _____			

Alternative Emergency Contacts

If unable to reach either parent, please contact:

Primary Emergency Contact _____		Secondary Emergency Contact _____	
() _____ Home Phone	() _____ Cell-Phone	() _____ Home Phone	() _____ Cell-Phone

Medical Information

Child's Physician's Name _____	Phone Number _____
Insurance Company _____	Policy Number _____

Allergies/Special Health Considerations

If unable to be reached in the event of an emergency, I give my consent to have my child taken to Paoli Hospital.

Parent's/Guardian's Signature _____ Date _____

Please note: We do not require students to have a physical examination before beginning school, but immunization record is necessary. Please return this form with immunization record completed.

VACCINE Circle appropri. item	Enter Month, Day and Year each Immunization was given				
Diphtheria and Tetanus (DTaP, DTP, Td or DT)	1	2	3	4	5
Polio (OPV or IPV)	1	2	3	4	
Hepatitis B	1	2	3		
Measles - Mumps - Rubella (MMR)	1	2	Or Measles Serology: Date: _____ Titer _____		
Varicella "Chickenpox" (Vaccine or Disease)	1	2	Or Measles Serology: Date: _____ Titer _____		
Other	1	2	Mumps disease diagnosed by a physician, date: _____		

I give my permission for the staff of the Preschool in the Valley to photograph my child for in-house purposes (e. g. photo albums, bulletin boards). I also give my permission for pictures of my child to be posted on secure internet photo sharing websites such as Kodak or shutterfly.com, for parent use only (there will be no names posted with the images).

Signature _____ Date _____