

**Cross Light Christian Preschool
Childs Personal Data Sheet**



1. Demographics

Name: _____ DOB _____

Home address _____

City _____ State _____ Zip _____ Phone _____

Fathers Name _____ lives with child Yes no

Father's Employer _____ work phone _____

Cell phone _____ E-mail address _____

Mothers name _____ lives with child Yes no

Mother's Employer _____ work phone _____

Cell phone _____ E-mail address _____

2. Emergency Contact Information

Person to call if parents cannot be reached:

Name: _____ Relationship _____

Address _____ Telephone _____

Is this person authorized to take the child from MDO? Yes no

List ALL adults who are authorized to take the child from MDO:

A. Name _____ Relationship to child _____

Address _____

Phone # _____ Additional phone# _____

B. Name _____ Relationship to child _____

Address _____

Phone # _____ Additional phone# _____

C. Name _____ Relationship to child _____

Address _____

Phone # _____ Additional phone# _____

This is a code word known only by the parents and/or the people who are authorized to pick up your child in the event that there is a change in the pick up information that cannot be made in person. Choose a word that you will remember.

Secret Passcode: _____

3. Medical Information

Childs physician _____
Address _____
Phone # _____

I, _____ (mother, father or guardian) of _____ do hereby give my consent to the Director of MDO or her duly appointed representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon and/or to transport said child for emergency medical treatment, if the parents cannot be reached.

Signed _____ Date _____
Witness _____ Date _____

The Director of MDO or her/his appointed representative has my permission to administer the age appropriate dose of acetaminophen to my child. I understand that I will be notified that the medication has been administered.

Signature _____ Date _____

4. Immunizations: Please provide a copy of your Child’s Immunization Record Verified by Health Department Record or Physician’s Record

5. Disease History: list the dates of each:

Measles _____ Mumps _____ German measles _____ Chicken Pox _____
Whooping Cough _____ Tuberculosis _____ Frequent Ear Infections _____
Heart Problems _____ Seizures _____ Diabetes _____ Other _____

6. Child’s Development needs

Physical or emotional problems the child might have:

Child’s special food needs:

Special Problems:

Medication: (Please list name, dose, and how often.)

Allergies: (Both food & drug) _____

Diabetes Care: _____
(Please explain if necessary)

Requires help in: Dressing _____ Undressing _____ Toileting _____ Eating _____

Hand Washing _____

Is Child toilet trained? ? Yes no

Words used in toileting _____

Favorite: Games _____

Toys _____

Foods _____

Siblings? ? Yes no

Name(s) and ages of siblings: _____

Type of child care used before: _____

Other useful information: _____

I, the parent/guardian of this child, understand that I may ask for a conference with the caregiver(s) as needed.

Signature _____ Date _____

Thank you!

Laura Law, Director

FOR OFFICE USE ONLY

Date Enrolled _____ Date withdrawn _____