Last Name: _____ **First Name:** _____ **Date:** _____

PACIFIC GROVE PRESCHOOL
STUDENT EMERGENCY CONTACT CARD

Student Last Name:	**First Name:**				**Middle Name:**
Birth date:	**Age:**	**Student Gender**	**(Circle) M**	**(Circle) F**	**Home Phone:**
Street Address:	**Apartment Number:**				**City, State:** **Zip Code:**
Mailing Address:	**Apartment Number:**				**City, State** **Zip Code:**

Student currently resides with: a) Mother and Father – one household b) Separate Households: Part Time Each Parent c) Single Parent: Mother or Father
(Please Specify) d) Mother/Stepfather e) Father/Stepmother f) Legal Guardian **(circle one)**

Father's Name:		**Father's Home Address:**	**Father's Home Phone:**
Employer:		**Occupation:**	**Work Phone:**
E-mail:		**Cell Phone:**	
(If applicable)	**Stepmother's Name:**	**Cell Phone:**	**Work Phone:**

Mother's Name:		**Mother's Home Address:**	**Mother's Home Phone:**
Employer:		**Occupation:**	**Work Phone:**
E-mail:		**Cell Phone:**	
(If applicable)	**Stepfather's Name:**	**Cell Phone:**	**Work Phone:**

IS THERE A COURT-MANDATED CUSTODY OR VISITATION ORDER LIMITING ACCESS TO THE STUDENT? YES NO
(If YES, make sure that the school office has a copy of the Court order on file) **(Please circle one)**

Office Use Only

[ ] Medical [ ] Custody Special Needs [ ]

Changes: Date:_____ PS _____ Date:_____ PS _____ Date:_____ PS _____

EMERGENCY CARD (continued)

The following information will be used in the event that your child becomes ill or is injured while at school or in case of an impending or natural disaster and you cannot be reached. In cases of a minor nature, first aid will be administered. It is understood that the instructions given on this card will remain in force until revoked by the parent or guardian. In the case of an emergency or illness concerning your student,, where you cannot be reached please list three or four LOCAL persons who will be available (these should be persons to whom the student can be released from campuses, if needed).

Name	**Relationship**	**Phone:**
Name	**Relationship**	**Phone:**
Name	**Relationship**	**Phone:**
Name	**Relationship**	**Phone:**

In the event of a serious injury or illness the school will call 911 and provide the following information to emergency personnel:

Doctor's Name		**Phone Number**	
Dentist's Name		**Phone Number**	
Insurance Company		**Policy Number**	

Health Problems: Please specify anything which would limit activity or may require special care during this school year (e.g., cardiac, diabetes, epilepsy, orthopedic, severe allergies, emotional; also include any hearing, vision or speech problems):

List any medication being taken by your child along with dosage and how many times taken per day:

I also give the Recreation Department permission to use my child's photo image in advertising this program.

Date: _____

_____

Signature of Parent or Guardian

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____ (NAME OF CHILD), born _____ (BIRTH DATE) is being studied for readiness to enter

_____ (NAME OF CHILD CARE CENTER/SCHOOL). This Child Care Center/School provides a program which extends from _____ : ____

a.m./p.m. to _____ a.m./p.m., ____ _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ (SIGNATURE OF PARENT/DOMESTIC PARTNER,GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) _____ (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND (ACELLULAR) PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present: TB skin test not required.

☐ Risk factors present: Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____
Address: _____
Telephone: _____

Date of Physical Exam: _____
Date This Form Completed: _____
Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practioner

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent, Domestic Partner or Authorized Representative

CHILD'S NAME LAST | MIDDLE | FIRST | SEX | TELEPHONE ( )

ADDRESS NUMBER | STREET | CITY | STATE | ZIP | BIRTHDATE

FATHER'S/GUARDIAN'S/DOMESTIC PARTNER'S NAME LAST | MIDDLE | FIRST | BUSINESS TELEPHONE ( )

HOME ADDRESS NUMBER | STREET | CITY | STATE | ZIP | HOME TELEPHONE ( )

MOTHER'S/GUARDIAN'S/DOMESTIC PARTNER'S NAME LAST | MIDDLE | FIRST | BUSINESS TELEPHONE ( )

HOME ADDRESS NUMBER | STREET | CITY | STATE | ZIP | HOME TELEPHONE ( )

PERSON RESPONSIBLE FOR CHILD LAST NAME | MIDDLE | FIRST | HOME TELEPHONE ( ) | BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE ( )

DENTIST | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT, DOMESTIC PARTNER OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN/DOMESTIC PARTNER OR AUTHORIZED REPRESENTATIVE | DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION | DATE LEFT