

THIS FORM MUST BE FILLED OUT ENTIRELY

Walnut Creek Presbyterian Church Preschool
Identification and Emergency Information 2018/2019

1801 Lacassie Avenue Walnut Creek, CA 94596
Phone: 925-935-1669 FAX: 925-935-1737

Child's Last Name _____ First _____ To Be Called _____

Birthdate ____/____/____ Boy ____ Girl ____ State or Country of Birth _____

FAMILY INFORMATION

Address _____ City _____ Primary Contact # _____

Home Phone _____

E-mail _____ Zip Code _____

Father's Name _____ Occupation _____ Work Phone _____

Cell Phone _____

Mother's Name _____ Occupation _____ Work Phone _____

Cell Phone _____

Toilet Trained Yes ___ No ___ In Progress ___

Siblings Living at Home:

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Person Responsible For Tuition Payments: _____ Same address as above

Name _____ Address _____ City _____ Zip _____

MEDICAL INFORMATION (REQUIRED INFORMATION)

Child's Physician _____ Phone _____

Emergency Hospital Preference _____ Phone _____

Known Allergies, Medications, or Food Restrictions _____

PERSONS AUTHORIZED TO PICK UP CHILD OR TO BE CALLED IN AN EMERGENCY

Name _____ Phone: _____ Cell: _____

Name _____ Phone: _____ Cell: _____

Name _____ Phone: _____ Cell: _____

Name _____ Phone: _____ Cell: _____

Name _____ Phone: _____ Cell: _____

Out of State Contact: Name & Phone Number _____

Names of the above are authorized to take child from Preschool. Child will not be allowed to leave with any other person without written authorization from the parent or guardian.

I hereby give permission for my child to participate in all special events and walking field trips which may be part of the educational program. I understand that responsible adults will accompany my child during these activities.

In case of an emergency, if a parent or guardian cannot be reached, I authorize a school representative to make the necessary arrangements for my child to receive medical or hospital care, including transportation. If my doctor is unavailable, I authorize any licensed physician or surgeon to treat my child. Any expenses incurred will be accepted by me.

Signature of Parent or Guardian

Date
