EMERGENCY INFORMATION

Please fill in all blanks completely

CHILD'S NAME: _____ **AGE:**_____ **BIRTHDATE:**_____
ADDRESS:_____
City, State, Zip: _____

Grade: _____ **School Attended Last Year:**_____

Mother's name:_____ Father's name:_____
Home #:_____ Home # :_____
Work #: _____ Work #: _____
Cell/Pager #:_____ Cell/Pager #:_____
E-mail address:_____ E-mail address:_____

Hospital preference:_____ Phone #:_____
Physicians: Pediatrician:_____ Phone #:_____
Neurologist: _____ Phone #:_____
Orthopedist _____ Phone #:_____
Dentist:_____ Phone #:_____
Other:_____ Phone #: _____
Therapists: Occupational:_____ Phone#:_____
Physical:_____ Phone #:_____
Speech:_____ Phone #:_____
Other:_____ Phone #:_____
May we contact any of the above regarding your child's progress? Yes_____ No_____

Diagnosis: _____
Allergies: 1._____ reaction:_____ treatment:_____
2._____ reaction:_____ treatment:_____
Special Diets: Food restrictions:_____
Reason(s):_____
Special feeding method:_____

Primary Insurance Coverage: (Please attach copy of insurance card)
Secondary Insurance Coverage: (Please attach copy of insurance card)

Emergency Contacts: (These are the only people other than the parents who have permission to pick up my child from school when necessary)
Name:_____ **Relationship:**_____ **Phone #:**_____
Name:_____ **Relationship:**_____ **Phone #:**_____

I understand that it is my/our responsibility to keep all information regarding my child current and up to date with the school office . I understand this information will be used for contacting us during normal school hours, BSC/AFSC and on school field trips.

Parent signature:_____ **Date:**_____

List any major illnesses and/or operations your child has had:
1._____
2._____
3._____
4._____

Does your child have any hearing or vision problems? **Yes**_____ **No**_____
If yes, please explain:_____

Are your child's immunization's current and up-to-date? **Yes**_____ **No**_____
Please be aware that copies of these records are required by all students at the time of registration. If you have chosen *not* to have your child immunized, we must have a copy of the waiver provided by the local health department.

Feeding Method: (please circle the method your child prefers)
Fingers_____ Spoon_____ Fork_____ Requires being fed_____ Other_____
Do you feel your child is a healthy eater? **Yes**_____ **No**_____
Any additional information regarding foods or feeding?_____
Concerns/Goals_____

Is your child potty trained? **Yes**_____ **No**_____

_____

Please tell us about your child

My child is:
_____ **verbal**
_____ **partially verbal**
_____ **non-verbal**

My child communicates through:
(please check all that apply)
_____**sign-language**
_____**augmentative communication devices**
_____**picture exchange**

What does your child enjoy doing most?_____
Does your child play well with others?_____
Does your child experience anxiety in certain situations? If so explain._____
_____
Does your child exhibit self-control or impulse problems? If so explain. _____
_____
Does your child exhibit behaviors that concern you? If so explain. _____
_____
When stressed or anxious what comforts your child?_____
_____
How do you manage your child's behavior?_____
_____

Is there anything else we should be aware of concerning your child?_____
_____
_____
_____
_____
_____