



EMERGENCY AND MEDICAL INFORMATION FORM

**Please complete and return BEFORE school begins.
Your child may not attend school without a copy of this form on file.**

CHILD'S INFORMATION		
Child's name (last, first, MI):	Date of birth:	
MEDICAL INFORMATION		
Pediatrician's name and practice name:	Phone number:	
Does your child have any physical or emotional difficulties we should be aware of? <input type="checkbox"/> No <input type="checkbox"/> Yes, please describe below:		
Does your child receive support services (e.g., speech/language therapy) or need RSP to provide other services?: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide contact information for therapists and copies of most recent evaluations.		
Does your child have any allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes Please list:		
Does your child need an Epi-pen? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide a doctor's note or prescription for RSP, and 2 unexpired epi-pens.		
Does your child require Benadryl or other antihistamine? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide a doctor's note or prescription for RSP as well as an unopened, unexpired container of the medication.		
Is your child allergic to bee stings? <input type="checkbox"/> No <input type="checkbox"/> Yes, please include reaction details below:		
EMERGENCY CONTACT INFORMATION		
Individuals to contact if Rock Spring Preschool is unable to reach parents/guardians in event of an emergency:		
Name:	Phone number:	Relationship to child:
1.		
2.		
Rock Spring Preschool may release my child to the following individuals (full name and relationship to child).		
Name:	Phone number:	Relationship to child:
1.		
2.		
PARENT AGREEMENT <i>(please write your initials in the box to the left of the agreement below and sign the authorization at the bottom of this page.)</i>		
<input type="checkbox"/> I have read the Rock Spring Preschool Parent Handbook and agree to abide by the policies stated therein; <input type="checkbox"/> and, I have answered the questions on this form accurately to the best of my ability; <input type="checkbox"/> and, I have provided original documentation of Immunization (form 3231) and agree to provide current documentation as information is updated.		
EMERGENCY MEDICAL AUTHORIZATION		
(To be used in the event of emergency when a parent, guardian or emergency contact cannot be reached.) In cases of emergency, Rock Spring Preschool uses Children's Healthcare of Atlanta at Egleston as its main facility. The address is: 1405 Clifton Road, NE. 404-325-6400.		
The undersigned parent(s) or guardian(s) hereby give consent and authorize a representative of Rock Spring Presbyterian Church, Inc., to obtain appropriate medical transport, care, and treatment on behalf of the undersigned, as if personally done by the undersigned, for the purposes of stabilization until such time as I/we can be notified. All acts so done are hereby expressly ratified.		
Please note ANY MEDICATION to which your child is allergic or any other conditions you feel are important. (Use additional pages as necessary.)		
Parent (guardian) signature:	Date:	
Parent (guardian) signature:	Date:	