Jewish Community Alliance of Southern Maine

JCA Early Childhood Education Child Record 2017-2018

NAME OF CHILD _____ Birthdate_____
Home Address _____
PARENT 1 _____ Cell Phone_____
Home Address (if different from above) _____
Home Phone_____ Work Phone _____ E-mail_____
Name of Employer _____
Employer's Address _____
PARENT 2 _____ Cell Phone_____
Home Address (if different from above) _____
Home Phone _____ Work Phone _____ E-mail _____
Name of Employer _____
Employer's Address _____

IN CASE OF EMERGENCY AND YOU CANNOT BE REACHED, PLEASE LIST PEOPLE WE CAN CONTACT:
Name _____ Relationship _____ Phone_____
Name _____ Relationship _____ Phone_____
The following people are authorized to pick up your child from school, should the need arise:
Name _____ Relationship _____
Name _____ Relationship _____

MEDICAL CONTACTS
Name of dentist/orthodontist _____ Phone _____
Address _____
Name of family physician _____ Phone _____
Address _____
Do you carry family medical/hospital insurance? Yes / No
If so, indicate: Carrier _____ Policy or Group _____

HEALTH HISTORY

Diseases	**Dates**
Frequent Ear Infections	
Poison Ivy	
Chicken Pox	
Convulsions	
Measles	
Diabetes	
German Measles	
Bleeding/Clotting Disorders	
Mumps	

Hypertension _____
Mononucleosis_____
Asthma _____

Allergies	**Dates**
Hay Fever	
Poison Ivy	
Insect Stings	
Penicillin	
Other Drugs	

Operations or serious injuries (dates) _____
Chronic or recurring illness or medical condition _____
Dietary restrictions _____
Current medications (send with instructions) _____
Other diseases _____

Please include any further information on the back of this sheet.

MEDICAL RELEASE
I hereby give my consent, in the event of a medical emergency when I cannot be contacted, for the JCA to obtain whatever treatment may be deemed necessary for (child's name)_____(DOB)_____
This authorization includes my consent for the above-named child to receive treatment by a physician in any hospital emergency department. I hereby give my authorization for emergency medical treatment as outlined above.

PERMISSION SLIP
I GIVE PERMISSION TO THE STAFF AT THE JEWISH COMMUNITY ALLIANCE EARLY CHILDHOOD EDUCATION PROGRAM TO: (parent / legal guardian please check all that apply.)

☐ Take pictures/videos of my child for classroom use and other public purposes.
☐ Take walking fieldtrips around the neighborhood.
☐ Apply additional sunscreen if needed.
☐ Apply additional bug spray if needed.
☐ Distribute my name, address, and phone numbers to other parents on classroom list.
☐ Post my child's allergies.
☐ Apply diaper rash ointment (if applicable).

I HAVE READ THE PARENT HANDBOOK AND BY SIGNING BELOW AGREE TO THE POLICIES THERE IN.
Parent/Guardian Signature_____**Date**_____