Jackson Center Schools

Pre- Kindergarten

Child's Name:_____ Date of Birth:_____

Address:_____ Home Phone:_____

Parent/Guardian Name:_____ Cell Phone:_____

Home Address: _____ Home Phone:_____

Employer name & address: _____

Work Phone:_____

Please circle which phone number should be used 1st 2nd 3rd to reach you while your child is in the program. Cell 1 2 3 Home 1 2 3 Work 1 2 3

Employer name & address: _____

Work Phone:_____

Please circle which phone number should be used 1st 2nd 3rd to reach you while your child is in the program. Cell 1 2 3 Home 1 2 3 Work 1 2 3

Employer Address_____

Please list two people to be contacted in the event of an emergency
if the parent cannot be contacted:

Name	Name
Address	Address
City	City
State Zip	State Zip
Relationship to child	Relationship to child
Home Phone	Home Phone
Cell Phone	Cell Phone
Work Phone	Work Phone

Physician: **Dentist:**

Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone	Phone

Annual Class Roster

Each year we prepare a roster for each group of children in our program. This roster will not be furnished to any persons other than parents of children enrolled in our program.

I authorize the following to be listed on the parent roster – **Please circle one.**

My child's name YES NO
Parents/Guardians name YES NO
Phone Number WORK/MOBILE/HOME NO

Signature of parent, or guardian. Date

CHRONIC PHYSICAL PROBLEMS:_____

HISTORY OF HOSPITALIZATION:_____

DISEASES THIS CHILD HAS HAD:_____

ALLERGIES AND TREATMENT:_____

MEDICATIONS, FOOD SUPPLEMENTS, MODIFIED DIET OR FLUORIDE

SUPPLEMENTS:_____

List of persons to whom this child can be released: List of persons NOT permitted to pick up this child:

IMPORTANT: PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS

Exempt from Immunizations:
Religious conviction YES NO

Parent/Guardians signature for immunization exemption:

_____