Please give any pertinent information regarding the health of this child:

EMERGENCY CARD
Office of Catholic Schools
Diocese of Columbus

_____
School
School Year 20 ____ - ____

Student's Name _____ Room _____

Address _____

_____ Zip _____

Phone _____ Birthdate _____

Father/Guardian's Name _____

Address _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone/Pager _____

Email _____

Place of Employment _____

Mother/Guardian's Name _____

Address _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone/Pager _____

Place of Employment _____

Email _____

In the event this student becomes ill at school but does not need medical attention, name three people, i.e., relative, neighbor, child care provider, to be contacted if you cannot be reached.

1. _____ Relationship _____ Phone _____

2. _____ Relationship _____ Phone _____

3. _____ Relationship _____ Phone _____

(See reverse side and inside of card.)

EMERGENCY MEDICAL AUTHORIZATION

(State of Ohio Revised Code Section 3313.712)

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____ Phone (___) _____

Dentist _____ Phone (___) _____

Medical Specialist _____ Phone (___) _____

Local Hospital _____ Emergency Room Phone (___) _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physicians should be alerted:

_____

_____

Date _____ Signature of Parent/Guardian _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

Date _____ Signature of Parent/Guardian _____

ED 3301-12 2/89

ST. MARY PRESCHOOL
PRESCHOOL ROSTER

The Preschool annually prepares a school roster which is available to parents or guardians of the children.

Please fill out the bottom section completely if you would like to be included on the roster.

We will NOT include the name, address, or phone number of anyone who does not wish to be listed on the roster. If you do NOT wish to be listed, sign and date the top section, leaving the fill-in information section at the bottom blank.

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

_____I do NOT wish to be listed on the Preschool Roster.

Child's name _____

Date: _____ Parent's Signature _____

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

_____I DO wish to be listed on the Preschool Roster.

(Please print the following information as you want it to appear):

Child's name : _____
(last) (first)

Parent (s) First Name: _____

Street Address: _____

City and Zip: _____

Telephone: _____

Date: _____ Parent's Signature: _____

ED 3301-12 2/89

ST. MARY PRESCHOOL

CHILD INFORMATION SHEET

CHILD'S FULL NAME: _____ BIRTH DATE: _____

CHILD'S FIRST NAME (to be used in school): _____

PARENT NAMES: _____

1. HAS YOUR CHILD ATTENDED A PRESCHOOL PRIOR TO THIS ONE? _____
   If so, what school? _____

2. HAS YOUR CHILD ATTENDED A LIBRARY STORY HOUR? _____

3. IS LANGUAGE OTHER THAN ENGLISH SPOKEN AT HOME? _____
   If so, please indicate the spoken language _____

4. DOES YOUR CHILD HAVE PLAYMATES HIS/HER OWN AGE? _____

5. DOES YOUR CHILD HAVE A HOBBY OR SOME SPECIAL INTEREST? _____
   If so, please indicate _____

6. DOES YOUR CHILD HAVE ANY PHYSICAL PROBLEMS ? _____
   (For example, an allergy, hearing, speech, or vision problem) _____
   _____

7. DOES YOUR CHILD HAVE ANY FEARS WE SHOULD BE AWARE OF? _____
   If so, what? _____

8. DOES YOUR CHILD HAVE AN OLDER BROTHER OR SISTER AT THIS SCHOOL?
   Please list their names and grades they are in _____
   _____

9. DO YOU HAVE AN OCCUPATION, HOBBY, OR PASTIME THAT YOU WOULD BE WILLING TO SHARE IN YOUR CHILD'S CLASSROOM? _____
   If so, please describe _____

10. DO YOU HAVE ANY EXPECTATIONS FOR YOUR CHILD'S ACTIVITIES OR PROGRESS IN PRESCHOOL THIS YEAR? _____
    _____
    _____

ADDITIONAL COMMENTS OR INFORMATION ABOUT YOUR CHILD THAT YOU THINK MIGHT BE HELPFUL TO US: _____
_____

ED 3301-12 2/89

ST. MARY PRESCHOOL
AUTHORIZED PICKUP LIST

For your child's protection, please fill out the name of authorized person (s) (other than yourself) to bring or take your child from the Preschool. If you cannot do this now, do it at the start of school and whenever any changes are in order.

Please inform the authorized persons to be prepared to identify themselves to our staff (driver's license).

List parent other than one signing this, if authorized to pick up.

NAME: _____ Relationship to child: _____

NAME: _____ Relationship to child: _____

NAME: _____ Relationship to child: _____

NAME: _____ Relationship to child: _____

NAME: _____ Relationship to child: _____

In case of car pool arrangements, designate such on the line "relationship" or tell us here what the arrangements will be (please be specific as to days and names):

_____

_____

_____

_____

Is there anyone that you do NOT wish to have your child released?: _____

_____

_____

SIGNATURE: _____ DATE: _____

ED 3301-12 2/89

OHIO DEPARTMENT OF EDUCATION

DIVISION OF EDUCATIONAL SERVICES
EARLY CHILDHOOD EDUCATION SECTION
CHILD MEDICAL STATEMENT

This is to certify that I have examined (Child's name) _____
on (date) _____ and have found that s/he:

1) has had the Immunizations required by SECTION 331.671 of THE OHIO REVISED CODE for admission to school, or has had the Immunizations required by the OHIO DEPARTMENT OF HEALTH for Infants and Toddlers, or
____is to be exempted from these requirements for medical or religious reasons.

IMMUNIZATION RECORD: Enter month/day/year of each immunization.

DTP: 1_____ 2_____ 3_____ 4_____ 5*_____

POLIO: 1_____ 2_____ 3_____ 4*_____

MMR** 1_____

HIB: 1_____

**If measles, mumps, rubella not given as MMR, give dates for each immunization:

Measles _____ Mumps _____ Rubella _____

*The 5th DTP and 4th polio should be administered just prior to preschool or school entrance.

2) is free from apparent communicable disease and is in suitable condition to attend a preschool program, based on his/her medical history and physical condition at the time of this examination.

Physician's Signature

Physician Name (Print)

Address

City, State, Zip

Phone

Parent Name Child's Birth date

ED 3301-12 2/89

OHIO DEPARTMENT OF EDUCATION
DIVISION OF EDUCATIONAL SERVICES
EARLY CHILDHOOD EDUCATION SECTION

CHILD'S HEALTH INFORMATION FORM

Rule 3301-37-05 of the Administrative Code requires preschool programs to secure health information from a child's parent no later than the first day of attendance unless otherwise indicate d.

Name of Child (print or type) _____ Date of Birth Name of Parent/Guardian _____

_____

Height Weight

1. Allergies (List all allergies affecting the child and any special precautions or treatments indicated for these allergies.) _____

2. Medications (List all medications currently being administered to the child.) _____

3. Chronic Physical Problems (List all chronic physical problems affecting the child.) _____

4. History of Hospitalizations (List dates of all hospitalizations of the child.) _____

5. Diseases (List all diseases the child has had.) _____

_____

Name of Person Completing this Form Date

_____