Contact Update Form

Child's Last Name First Middle Date of Birth

Parent/Guardian 1	Parent/Guardian 2
Name	Name
Address	Address
City Zip	City Zip
Home phone	Home Phone
Work Phone	Work Phone
Cell	Cell
Occupation/Employer	Occupation/Employer
Who is the child's primary parent/guardian? (circle one) mother father both (together) both (shared) other	

Emergency Contact List
Please list in order of priority, the people you would like us to call in case of an emergency (when parents/guardians cannot be reached).

Name	Address (required)	Primary Ph #	Relationship to Child:

Authorized Pick-Up List
Please list ALL people authorized to pick-up your child, including people also listed as Emergency Contacts.

Name	Address (required)	Primary Ph #	Relationship to Child:

Parent/Guardian Signature: ______________________________________ Date: _________________

Print Full Name: ______________________________________

By singing above, I acknowledge that I have read and understand the current LSA Parent Handbook, and the policies therein. The handbook can be found at www.latonaschoolassociates.com.
I agree to update this information as necessary so as to ensure its accuracy.

NAME OF CHILD: ____ **DATE OF BIRTH:** ____________________

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the Latona School Associates (LSA) Child Care to transport my child and to secure for my child the necessary medical treatment including but not limited to medical, dental, and surgical care. I understand the teachers at LSA Child Care are trained in the basics of First Aid/CPR and I authorize them to give my child First Aid/CPR when appropriate. I give consent for the staff of Latona School Associates to act on my behalf until I am available. I will be responsible for all charges not covered by insurance. I agree to review and update this information whenever a change occurs. I certify that I am the parent or guardian of the above named child and have legal authority to consent to such activities and actions.

CONTACT INFORMATION:

Parent/Guardian Name:	HM #:	Parent/Guardian Name:	HM #:
Address:	WK #:	Address:	WK #:
	Cell #:		Cell #:

Is your child allergic to any medications?

ALLERGY:	REACTION:

Does you child have any existing medical conditions?

CONDITION:	MEDICATION OR TREATMENT:

PREFERRED HOSPITAL:		
MEDICAL INSURANCE:		POLICY #:
PHYSICIAN NAME/ADDRESS:		PHONE:
DENTIST NAME/ADDRESS:		PHONE:

EMERGENCY CONTACTS: (please include parents/guardians and list in preferred order of priority)

NAME/RELATIONSHIP TO CHILD	HOME PHONE #	WORK PHONE #	CELL PHONE #

PARENT/GUARDIAN SIGNATURE: ____

PRINT FULL NAME: ____ **DATE:** ____________________________

Health History Form

Name of Child: ____ Birth date: _______________

Date of last Physical Exam: ________________ Today's Date: _______________

Does your child have? (please check)		Has your child had any of these diseases? (please check and date)		Date:
Frequent Colds	______	Bronchitis	______	_______________
Frequent Sore Throat	______	Ringworm	______	_______________
Frequent Ear Infections	______	Impetigo	______	_______________
Problems w/Skin Rash	______	Head Lice	______	_______________
Heart Trouble	______	Chickenpox	______	_______________
Convulsions	______	Hepatitis	______	_______________
Fainting Spells	______	Scarlet Fever	______	_______________
Diabetes	______	Tuberculosis	______	_______________
Asthma	______	Measles (Hard)	______	_______________
Stomach Upsets	______	German Measles (3 day)	______	_______________
Urinary Problem	______	Mumps	______	_______________
Problems w/Diarrhea	______	Poliomyelitis	______	_______________
Problems w/Constipation	______	Whooping Cough	______	_______________
Problems w/Soiling	______	Worms	______	_______________

Has your child had illnesses other than those listed above?
(If so, please explain)

____

____

____

Has your child ever been hospitalized? (If so, please explain)

____

____

____

Has your child had injuries with fractures or loss of consciousness?
(If so, please explain)

____

____

____

When was your child's vision and hearing last tested? (by whom?)

____

____

____

When did your child last visit the dentist?

____

____

Is there a family history of… (circle one)

Asthma? **YES / NO** (if "yes", additional form required)
Allergies? **YES / NO** (if "yes", additional form required)
Epilepsy? **YES / NO**
Diabetes? **YES / NO**

Please list **ALL FOOD** Allergies or write "not applicable":

____

____

____