

Epiphany Preschool Registration Form

Church of the Epiphany
3301 Hidden Meadow Drive, Herndon 20171
(703) 481-8601 ext.116

Spring Session – Parent's Day Out

March – May 2010

Registration Fee ~ \$25.00
Fridays \$100 per month

Epiphany Preschool Office Use Only

Reg. Fee \$ _____ Place of Birth: _____
Check # _____ Birth Certificate Number: _____ Verified By: _____
Date _____

Child's Name: _____ Name you want the child to be called in school: _____
Date of Birth ____/____/____ Male Female Home Phone: () _____
Address: _____ City: _____ State _____
Zip: _____ Subdivision: _____
Primary language spoken at home (please circle): Chinese English German Korean Spanish OTHER: _____

Father Information

Full Name: _____
Occupation: _____
Bus. Phone: _____
Cell Phone: _____
Address (If Not Child's): _____

Email address: _____

Mother Information

Full Name: _____
Occupation: _____
Bus. Phone: _____
Cell Phone: _____
Address (If Not Child's): _____

Email address: _____

Emergency Information

Please list two local people (other than parents) to contact in case of an emergency when parents can not be reached.
If English is not your primary language, one of your contacts must speak English.

Name: _____ Name: _____
Relationship: _____ Relationship: _____
Phone () _____ Phone: () _____
Alternate Phone: () _____ Alternate Phone: () _____

**** Students new to Epiphany Preschool must present a Birth Certificate or Passport at time of registration**

Child Information

The teacher finds this information helpful in preparing the classroom and getting to know your child.

Child's Full Name (include preferred name) _____

FAMILY LIFE

Adults who live in the home:

Siblings and their Ages:

Pets and their Names:

Ages and gender of the other children with whom your child interacts:

List your child's favorite play activities, toy, books and stories: _____

Please include what your child's comfort/security item is and its special name:

Does your child have any fears? YES NO If yes, please elaborate:

MEDICAL

Does your child have any allergies? YES NO

If yes, please describe the allergy and possible reactions: _____

Is an 'Epi-Pen' or Benadryl needed for allergies? YES NO

Does your child have any food restrictions? YES NO If yes, please be specific: _____

Does your child have any other medical conditions (asthma/diabetes/ epi-pen) which the Preschool should be aware of? YES NO If yes please be specific:

Will your child require medication to be kept at School? YES NO If yes, please list the medication(s) below:

CHILDCARE HISTORY

Does your child attend any other activities (Sunday school, Mother's Day Out, dance, etc)? YES NO

Please list: _____

Has your child attended any other nursery or child care center? YES NO

If yes, please note the name and type of Facility (ies): _____

All information on this form will be kept confidential.

Signature of Parent/Guardian

Date



Authorization for Emergency Treatment

I, _____, hereby authorize any physician
 (PARENT OR GUARDIAN)
 member of the Department of Emergency Medicine of Fair Oaks Hospital, Fairfax Hospital, Emergency Care Center of Reston / Herndon, and Mount Vernon Hospital or any member of the Medical Staffs of the Above mentioned hospitals requested by the Department of Emergency Medicine physician, to render medical treatment, which in his/her judgment may be deemed necessary in the care of

 (NAME OF CHILD OR DEPENDENT)

Child's Date of Birth: _____

Child's Allergies (if any): _____

Child's Dr.: _____ Telephone #: _____

Family Dr.: _____ Telephone #: _____

Medicines Child is taking: _____

Date of Last Tetanus Shot: _____

Outstanding Medical History (ex. Diabetes, Heart Disease, etc.): _____

Insurance Information

Insurance Company: _____

Identification / Policy No.: _____

Subscriber's name: _____

Subscriber's Place of Employment: _____

Subscriber's Telephone No.: _____

ALL PARENTS AND GUARDIANS ARE RESPONSIBLE FOR MAINTAINING THIS CONSENT FORM AS IT CANNOT BE MAINTAINED BY THE HOSPITAL.

 DATE

 SIGNATURE OF PARENT OR GUARDIAN

EPIPHANY PRESCHOOL EMERGENCY CARE INFORMATION

Student's Full Name _____

Date of Birth _____ (Please circle) Boy Girl

Home Address _____

Mother's Name _____ Father's Name _____

Home # _____ Home # _____

Work # _____ Work # _____

Cell# _____ Cell# _____

Local Emergency Contact (other than parent)

1. Name & Relationship _____

Home # _____ Cell # _____

2. Name & Relationship _____

Home # _____ Cell # _____

MEDICAL INFORMATION

List any medications taken regularly and adverse effects:

List any allergies and accompanying reactions:

Is the student under a physician's continuing care? If yes, please explain:

The school has my permission in an emergency when I and my emergency contact cannot be reached, to send my child to the emergency room of the nearest hospital, and the hospital and its' medical staff have my authorization to provide any treatment which a physician deems necessary for the well-being of my child.

Parent Signature _____ Date _____