Schaumburg Park District
Early Childhood Program
Student Information

Child's Name:_____

Name to be used by teacher:_____

Who will pick up your child:_____

Emergency Contacts/Authorized Pick Up
Please list individuals and phone numbers in the order that you would like them contacted. Individuals must have dry clothes and/or be able to pick up the child within 15 minutes. Please include parents if applicable.

	Name	Contact Number	Relationship to Child
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

MEDICAL HISTORY

Does your child have any food restrictions? Yes No If yes, please list:

_____

Does your child have any hearing, vision or physical limitations? Yes No If yes, please explain:

_____

Does your child have any of the following on-going medical conditions that we should be aware of?

	YES	NO	Describe	Medication Name (if required)
Allergies	☐	☐	_____	_____
Asthma	☐	☐	_____	_____
Seizures	☐	☐	_____	_____
Other	☐	☐	_____	_____

If you answered yes to any of the above questions and your child requires medication during class hours you must fill out an *Emergency Health Care Plan*, Permission to Dispense/Self-Administer Medication and Medication Dispensing Information.

I understand that in case of an emergency, every effort will be made to contact me. However, if I cannot be reached, I hereby authorize program staff to administer appropriate first aid and to have my child transported to the nearest hospital to secure the necessary treatment.

_____ _____

Parent Signature Date