

Peachtree Child Record Form

Today's Date: _____

Child's Date of Birth: _____

Child's Full Name: _____

Address: _____

Zip code: _____ Phone: _____

Parent/Guardian#1: _____

Occupation: _____ Employers Name: _____

Work phone: _____ Cell Phone: _____

Parent/Guardian #2: _____

Occupation: _____ Employers Name: _____

Work phone: _____ Cell Phone: _____

Emails: _____

Names of siblings:

_____ Age _____

_____ Age _____

Medical information:

Physician: _____ Phone #: _____

Dentist: _____ Phone #: _____

Insurance information:

Insurance company: _____

Name of subscriber: _____ Id number _____

PARENTS ARE RESPONSIBLE FOR ALL EMERGENCY MEDICAL TREATMENTS.

In case of emergency contact: _____

Relationship to child: _____ phone: _____

Other than the above parent/guardians, only the following person(s) may remove your child from care without previous notice. PHOTO ID WILL BE REQUIRED.

Name	Relationship	Phone
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_____	_____	_____
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_____	_____	_____
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Please list all allergies here:

Please list any other information below that you believe I should be aware of as your child's preschool teacher:

If any of the above information ever changes, please make me aware so that I may update your file.

*****Please return this form to peachtree along with updated shot records for your child as well as your Enrollment fee (non-refundable/to hold your spot) and thank you for choosing peachtree!*****

Please Sign and Date below stating you have read the parent handbook and agree to all of the terms.

Abby Lazarus
Peachtree SOECE
2020 E 11th st. #4, Cheyenne, Wy 82001
307-220-3051

Emergency Medical Authorization- Required by DFS

Childs Name: _____

Doctors Name: _____ Phone: _____

Dentist Name: _____ Phone: _____

Health Information such as allergies, chronic conditions or frequent hospitalizations:

Social or Family information or special concerns: _____

I, _____ hereby give permission to Peachtree SOECE and all staff to obtain medical or surgical care from a health care facility,

physicians or dentist for my child, whose full name is _____

_____ and date of birth is _____,

should the need arise.

It is understood that a conscious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by medical personnel may be taken. I further consent to transportation, by the provider or ambulance, of the above named child to the nearest or most appropriate medical facility.

Signature _____ Date _____