



**A CHILD'S WAY KINDERGARTEN-PRESCHOOL  
INFORMATION AND AUTHORIZATION FORM**

Complete, print and sign 3 copies of this form

Name of Child \_\_\_\_\_  M or  F Nickname \_\_\_\_\_

Birth date \_\_\_\_\_ Class and Teacher \_\_\_\_\_

Parent's Home E-mail Address \_\_\_\_\_

**PARENT(S) OR GUARDIAN(S) INFORMATION:**

Name(s): \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell phone parent 1: \_\_\_\_\_ Cell Phone parent 2: \_\_\_\_\_

Employer parent 1: \_\_\_\_\_ Work phone parent 2: \_\_\_\_\_

Employer parent 2: \_\_\_\_\_ Work phone parent 2: \_\_\_\_\_

If parent or guardian cannot be reached, list alternatives below:

Name & Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Name & Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone \_\_\_\_\_

**AUTHORIZATION FOR A CHILD'S WAY STAFF TO CONSENT TO TREATMENT OF CHILD**

We will always try to reach a parent or legal guardian if there is an emergency involving your child. If your child is involved in an accident that we feel is serious, we will call 911 which sends the rescue truck (paramedics) and ambulance. If the determination is made that emergency care is needed at the hospital, the ambulance will transport your child to St. Vincent Hospital or  \_\_\_\_\_ Hospital. Please notify us immediately if any of your phone numbers change.

As a parent or legal guardian of \_\_\_\_\_

Child's Name

Child's Birth date

I hereby authorize **A CHILD'S WAY KINDERGARTEN-PRESCHOOL STAFF at 12755 NW DOGWOOD ST., PORTLAND, OREGON 97229** access to medical information and to consent to any medical or surgical treatment of the above child which such staff members deem advisable in an emergency if a parent or legal guardian cannot reasonably be located when the child is brought for treatment. This authorization will be effective for the current school year.

√ *Signature of parent or legal guardian* \_\_\_\_\_ *Date* \_\_\_\_\_

**MEDICAL INFORMATION FOR \_\_\_\_\_ (child's name)**

CHRONIC ILLNESSES & ALLERGIES (food, pet, other): \_\_\_\_\_

EPI PEN: \_\_\_\_\_ YES or \_\_\_\_\_ NO

ALLERGIES TO MEDICATIONS: \_\_\_\_\_

FOOD PREFERENCES (ie. Vegetarian, gluten-free, vegan, etc.) \_\_\_\_\_

**I understand my child's food allergies or preferences will be posted in the classroom.**

√*Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

MEDICAL HISTORY, MEDICAL CONCERNS AND SPECIAL HEALTH NEEDS \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

Child's Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ Policy/Group ID number: \_\_\_\_\_

**PICK-UP AUTHORIZATION**

The following people are authorized to pick up my child:

Name	Relationship	Phone #	Cell Phone #
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____
4 _____	_____	_____	_____
5 _____	_____	_____	_____
6 _____	_____	_____	_____

√*Signature of parent or legal guardian* \_\_\_\_\_ *Date* \_\_\_\_\_

**PHOTO AUTHORIZATION FOR PICTURES TAKEN BY TEACHERS**

I give permission for my child to be photographed during classroom hours or fieldtrips by their teachers. The photos will be used to document my child's work and activities and will become part of my child's portfolio.

In addition, I do \_\_\_\_\_ or do not \_\_\_\_\_ authorize my child's picture to be put on our web site.

√*Signature of parent or legal guardian* \_\_\_\_\_ *Date* \_\_\_\_\_

**PHOTO POLICY FOR PICTURES TAKEN BY PARENTS**

Pictures or videos taken by parents that include children other than their own CANNOT be published or shared on any social networking site, including, but not limited to: Facebook, Twitter, MySpace, Blogger, Flickr, LinkedIn, Instagram, YouTube OR in e-mails.

√*Signature of parent or legal guardian* \_\_\_\_\_ *Date* \_\_\_\_\_