

Aldersgate Preschool

# Child Information Form

2313 Concord Pike

Wilmington, DE 19803

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Please contact preschool with any updates immediately.

Name of Child \_\_\_\_\_  
(FIRST NAME) (MIDDLE NAME) (LAST NAME)

Birthdate: \_\_\_\_\_ Date of Admission: \_\_\_\_\_ Discharge: \_\_\_\_\_

Name of Parent(s): (Father's name) \_\_\_\_\_  
(Mother's name) \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Mother's Cell Number: \_\_\_\_\_

Father's Cell Number: \_\_\_\_\_

Email Addresses (Mother): \_\_\_\_\_

Email Addresses (Father): \_\_\_\_\_

## Employer Information

1. Employer: \_\_\_\_\_ Hours of Employment: \_\_\_\_\_

Business Address: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Employer: \_\_\_\_\_ Hours of Employment: \_\_\_\_\_

Business Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## Religion

Religion: \_\_\_\_\_ Attending

Church: \_\_\_\_\_

## **Person other than parent to be notified in emergency situation OR Release of a child when parent is not available:**

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

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Names of Persons Other Than Parent to Whom Child May Be Released:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

*A note needs to be written for release of the child to someone other than the parent.*

**Emergency Medical Care Permission**

I, \_\_\_\_\_, the parent (or legal guardian) of \_\_\_\_\_ who is my minor child, hereby authorize emergency medical treatment for my child in the event I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment.

**Transportation Permission**

I, \_\_\_\_\_, the parent (or legal guardian) of \_\_\_\_\_ who is my minor child, hereby give permission for my child to be transported with his/her caregiver.

**Medical Information**

Child's Physician: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Office Hours: \_\_\_\_\_

Child's Dentist: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Office Hours: \_\_\_\_\_

**Special Medical Information (allergies, etc.):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please notify your child's teacher with the details*

**Health Insurance**

Medical Insurance Company: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Member ID #: \_\_\_\_\_

Dental Insurance Company (if different from Medical Insurance Company)  
Dental Insurance Company: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Member ID #: \_\_\_\_\_

**Parent Signatures**

X \_\_\_\_\_ Date: \_\_\_\_\_  
X \_\_\_\_\_ Date: \_\_\_\_\_  
Parent Signatures