

Bunny Tiger

Hippo Lion

Emergency Notification 2023-2024

Child's Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Mother's Name _____ Father's Name _____

Cell Phone # _____ Cell Phone # _____

Work # _____ Work # _____

Email _____ Email _____

Student Lives with: Mother Father Both Parents Other _____

Parent Signature Required: _____

In Case of Emergency or change of plans who has permission to pick up my child:

Name _____ Relationship _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Name _____ Relationship _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Name _____ Relationship _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Who does NOT have permission to pick up your child?

Name _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

In the case of separated/divorced parents or Child Protective Services decrees, are there any legal restrictions on the release of the child to either parent or family member? **Yes** **No** If yes, provide necessary legal documentation.

In the event of disaster with local phone lines interrupted, indicate a name and phone number of someone who lives out of state. This number may be contacted in a disaster only when parents can't be reached after 72 hours.

Name _____ Relationship _____

City _____ State _____ Zip Code _____

Phone Number _____

Treatment of Minor Children 2023-2024

I hereby give permission that my child _____ to be given treatment by a qualified child care staff member at InThe Beginning Preschool. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, hospital or aid car attendant when deemed necessary or advisable by the physician or aid care attendant to safeguard my child's health if I cannot be contacted. I waive my right of informed consent to such treatment.

I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. "I certify under penalty of perjury under the law of the State of Washington that the foregoing is true and correct."

Confidential Emergency Health Information

To provide a safe and healthy environment for your child this information will be accessible to the following people: Director, your child's teachers and medical emergency personnel.

Alert to Parents: If your child has a serious medical condition, it is vital that you discuss this with your child's teachers and the Director immediately. It is very important to know of LIFE-THREATENING conditions.

Medical History: (Check the ones that apply to your child and describe under the comment section)

- | | | |
|---|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Epi-Pen | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Autism Spectrum | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Color Blindness |
| <input type="checkbox"/> Anxiety/Panic Attack | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Vision Problems/Wears Glasses |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> PE Activity <input type="checkbox"/> Limited |
| <input type="checkbox"/> Bee Sting | <input type="checkbox"/> Hyperventilation | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Other |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Orthopedic Problem | |

Comments: _____

Allergies/Medicine: Please make sure an 'Allergy & Medical Questionnaire' forms, along with 'Authorization to Administer both Prescription and Over the Counter Medicine' forms have been filled out, signed and returned to Lead Teacher or Director.

Does your child have any allergies: Yes No If yes, what allergies? _____

How do you treat the allergy? _____

Is medication given at home for the allergy? Yes No If yes, what is the name of the medication? _____

Does your child take medication for other medical issues? Yes No If yes, to what medications and for what type of diagnosis? _____

Child's Physician _____ Physician Phone # _____

Child's Dentist _____ Dentist Phone # _____

Hospital Preference _____ Insurance Company _____

Insurance Group # _____ Insurance Membership # _____

List any operations, injuries or hospitalizations w/dates: _____

Washington State requires permission from parents for their child to use a hand sanitizer while in Preschool. ITBP strictly monitors and limits the use of this product to their students.

- Yes, I give my child's teacher permission to offer the use of hand sanitizer to my child.
 No, I do not give permission to my child's teacher to offer hand sanitizer to my child.

I give ITBP permission for the above categories and acknowledge this information is current and correct.

PARENT SIGNATURE: _____ Date _____