**ZION LUTHERAN ECC ENROLLMENT INFORMATION**

**CHILDS NAME**

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| **AUTHORIZATION FOR EMERGENCY MEDICAL INFORMATION:** | | |
| In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to: | | |
| Name of Licensed Physician | Address | Telephone No. |
| Name of hospital or clinic | Address | Telephone No. |

I give consent for necessary emergency treatment when my child is in the care of this physician and/or hospital/clinic.

Signature – Parent or Legal Guardian Date

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| ADDITIONAL PERSONS WHO MAY BE CALLED IN EMERGENCY: | | | |
| **NAME** | **ADDRESS** | **TELEPHONE** | **RELATIONSHIP** |
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I hereby authorize this child care facility to allow my child to leave the child care facility **ONLY** with the following persons: **(include telephone number)**

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List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries during the past one month, any medication prescribed for long-term continuous use, and any other information that staff should be aware of:

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**ADMISSION REQUIREMENT:**

Parent’s Statement: My child has been examined within the past year by a licensed physician and is able to participate in the child care program:

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| Name and Address of Physician OR Address of EPSDT Screening Site |

Within the next 12 months, I will obtain a physician’s statement, a copy of the medical screening form from the EPSDT Program, or a form or statement from a health service or clinic and will submit it to the day care facility.

**NOTE**: If medical diagnosis and treatment and/or immunization conflict with your religious beliefs, you

must sign an affidavit to that effect and attach it to this form.

If immunization would be injurious to your child or family, you must obtain a certificate

(signed by a physician) to that effect and attach it to this form.

My child’s immunization record is on file at the school and all immunizations are current. \_\_\_Yes \_\_\_N/A

\_\_\_\_\_ I acknowledge that my child has had vision/hearing testing at his/her Dr. office. (4 and 5 year olds only)

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Signature – Parent or Legal Guardian Date