

PEACE LUTHERAN PRESCHOOL AND DAYCARE

**EMERGENCY AND FAMILY INFORMATION FORM**  
(for Teacher and Office use only)

Child's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name child prefers to be called \_\_\_\_\_ Sex \_\_\_\_\_

Child's Home Address \_\_\_\_\_ Zip code \_\_\_\_\_

Child's Home Phone \_\_\_\_\_

**PARENT OR GUARDIAN INFORMATION**

FATHER's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Address (if different than above) \_\_\_\_\_

Father's Occupation and Place of Employment \_\_\_\_\_

\_\_\_\_\_ Work Phone \_\_\_\_\_

MOTHER's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's Address (if different than above) \_\_\_\_\_

Mother's Occupation and Place of Employment \_\_\_\_\_

\_\_\_\_\_ Work Phone \_\_\_\_\_

Child lives with:  Both Parents  Mother  Father  
 Other – specify: \_\_\_\_\_

**FAMILY INFORMATION**

Brothers and/or sisters (please indicate ages and whether they live with the child):

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

Please list any other persons living with the child and their relationship (if any) to the child):

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

Does your child have any pets? \_\_\_\_\_ If so, please list the kinds and names: \_\_\_\_\_

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

Have there been births, deaths, adoptions or other changes in the family structure which affected your child? \_\_\_\_\_

If so, please explain and describe the effect on your child: \_\_\_\_\_

\_\_\_\_\_

(Please continue on back)

What opportunities does your child have to play with other children?  neighborhood  
 Sunday school/church  Cousins/other family  
 Other school or camp environment If so, where \_\_\_\_\_

Does your child have any particular fears? \_\_\_\_\_ If so, please explain \_\_\_\_\_

How do you discipline your child? \_\_\_\_\_

What are your child's favorite play activities? \_\_\_\_\_

What communicable diseases has your child had? Indicate date and age:  
\_\_\_\_\_ Chicken pox \_\_\_\_\_ Measles \_\_\_\_\_ Mumps  
\_\_\_\_\_ Scarlet fever \_\_\_\_\_ Impetigo \_\_\_\_\_ Conjunctivitis

Does your child have frequent:  
 Colds  Coughs  Flu  Ear Infections  Sore Throats  
 Strep Throat  Upset Stomach  Other \_\_\_\_\_

Is your child allergic to anything? \_\_\_\_\_ If so, what is it and how does it affect him/her? \_\_\_\_\_

Has your child had serious illness, surgery or hospital stay? \_\_\_\_\_ If so, describe it and your child's reaction:

Is your child on any medication? \_\_\_\_\_ If so, in what dose, for what condition, and how does it affect him/her?  
(Please note that all medications must be kept in the office, with directions for use) \_\_\_\_\_

Is there anything else about your child we should know? \_\_\_\_\_

What do you expect from your child's preschool experience? \_\_\_\_\_

Parent/Guardian Signature

Date