



Confidential Student Information and Emergency Contact Form 2023-2024 School Year

Child's Full Name _____ DOB: _____

Child is called _____

Contacts

Parent/Guardian #1 Name _____

Employer _____ Occupation _____

Parent/Guardian #2 Name _____

Employer _____ Occupation _____

(If parents are separated or divorced, please provide pertinent custody arrangements to Director.)

Designated individuals authorized to pick up child in case of emergency closing or illness:

Caregiver Name _____ Cell Phone () _____

Additional Contact _____ Cell Phone () _____

Please list one contact person outside the DC area:

Name _____ Cell Phone () _____

Health & Development

Was your child delivered full term? _____ If not, how many weeks gestation at birth? _____

Describe anything unusual in the first year of development that we should be aware of (early illness, hospitalizations, etc.) _____

Does your child have any speech or motor delays? _____

If yes, is your child working with a therapist? _____

Is your child currently being treated for a chronic illness or condition that the school should be aware of? _____

Does your child have a diagnosed allergy, asthma, or medical condition that requires medication or treatment at school?

Yes No

If Yes, you must submit

• **DC Medication and Medical Procedure Treatment Plan**

And the applicable form(s) below

• **DC Action Plan for Anaphylaxis** (for allergies)

• **DC Action Plan for Asthma**



Home Environment

Sibling Name	Age	School

Pets at home _____

Languages spoken at home _____

Previous school _____ Dates _____ #days/week _____

Sleep: Times and lengths of naps _____

Comments _____

Nutrition: Favorite foods _____

Aversions _____

Toileting: Is your child toilet trained? (Not required for school attendance) _____

Does your child need adult assistance? _____

Comments _____

How is your child best soothed when upset? _____

Please share anything else you think would help us get to know your child or family.

Parent Signature _____ Date _____