



**Emergency Contact and Medical Information for a Child**

_____		_____		M	F
Child's Name		Date of Birth		Sex	
_____		_____		_____	
Parent's/Guardian's Name		Parent's/Guardian's Name		_____	
( ) _____	( ) _____	( ) _____	( ) _____	_____	
Home Phone	Work Phone	Home Phone	Work Phone	_____	
_____		_____		_____	
Address		Address		_____	
_____		_____		_____	
City, ST ZIP Code		City, ST ZIP Code		_____	

**Alternative Emergency Contacts**

I authorize that my child, \_\_\_\_\_, be released by Lakeshore Christian Preschool to the following persons, in addition to those already listed on this form.

Parent's/Guardians Signature \_\_\_\_\_ Date \_\_\_\_\_

_____		_____	
Primary Emergency Contact		Secondary Emergency Contact	
( ) _____	( ) _____	( ) _____	( ) _____
Home Phone	Work/Mobile Phone	Home Phone	Work/Mobile Phone
_____		_____	
Address		Address	
_____		_____	
City, ST ZIP Code		City, ST ZIP Code	
Relationship to child:		Relationship to child:	

**Medical Information**

\_\_\_\_\_

Hospital/Clinic Preference

_____	_____
Physician's Name	Phone Number
_____	_____
Insurance Company	Policy Number

Allergies/Special Health Considerations

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

\_\_\_\_\_

Parent's/Guardian's Signature Date



**Photograph Release**

I hereby grant permission for photographs of my child's activities at Lakeshore Christian Preschool for the use of training teacher and the public about early education. I understand that these photos may appear in forms such as display panels, videos, books, or brochures, and I agree that I am to receive no compensation for my child's appearance. I also understand that my child's participation confers on me no ownership rights to the photographs or negatives.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Child's Name \_\_\_\_\_

**Tuition Agreement**

I agree to pay my child's tuition by the first of each month. The annual tuition is broken up into 9 equal payments and I understand it is not pro-rated (except for PDO) based on the number of days of attendance. If the tuition is not paid within 7 days of the due date, I owe a \$15.00 late fee. If the tuition and late fee are not paid within 14 days of notification, my child will be replaced in the program. I understand there are no credits for absences. If the child is withdrawn from school on the advice of a physician, due to relocation, or by mutual consent of both parents and the school director, the tuition is cancelled for the remainder of the year. If the child is withdrawn for any other reason, the family is responsible for the tuition for the remainder of the year. I understand LCP requires 30 days written notice prior to my child's withdrawal from the school.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Annual tuition amount (PDO=\$675; 2YO=\$1,575; 3YO=\$1,935; 4YO=\$2,520) Monthly tuition amount if paid for 9 months (PDO=\$75; 2YO=\$175; 3YO=\$215; 4YO=\$280)

**Medication Consent**

I give permission for the below medication to be given to my child only as prescribed by \_\_\_\_\_ (name of physician). This medication may be given to the child until \_\_\_\_\_ (date or when empty).

Child's Name \_\_\_\_\_ Medication \_\_\_\_\_

Condition for which prescribed \_\_\_\_\_ Possible side effects \_\_\_\_\_

Dosage and time of administration \_\_\_\_\_ Other remarks \_\_\_\_\_

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Notary Public required for Medication Consent Only**

State of \_\_\_\_\_ County of \_\_\_\_\_  
This instrument was acknowledged before me on (date) \_\_\_\_\_ by \_\_\_\_\_

\_\_\_\_\_  
[Signature and seal of notary public]  
My commission expires: \_\_\_\_\_ [date].