

Childs Name: _____

Parent Authorization and Acknowledgement

Who can we contact OR release your child to in case of an emergency:

In the event that either parent cannot pick up their child, I authorize Little Lighthouse Preschool to allow my child to leave this facility with the following people. Please include ALL information.

Name _____ Driver's License # _____

Address _____ Phone Number _____

Name _____ Driver's License # _____

Address _____ Phone Number _____

I. Photographs

As your child participates in the program throughout the year, we would like to take some pictures to put together Memory Books. You can also sign up to receive pictures and videos through the **SeeSaw** app. Your signature gives your consent for your child to be photographed.

Parent Signature _____ Date _____

II. Parent Handbook and Discipline & Guidance

I acknowledge the access to the LLP Parent Handbook with our discipline policies at www.littlelighthousepreschool.org. I will carefully read the rules and policies of the handbook. I agree to abide by these policies and ask for explanations of anything that is not clear to me.

Parent Signature _____ Date _____

III. Nutritional Responsibilities

I acknowledge that meals and snacks are provided by families and the child-care center is not responsible for nutritional value or meeting the child's daily food needs.

Parent Signature _____ Date _____

IV. Health Form and Medical Release

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize **Little Lighthouse Preschool** staff to take my child to an Emergency Room or to the following physician or his/her associated, for medical care.

Child's Physician Name _____ Office Phone# _____

Doctor's Office Address _____

Hospital Preference _____

Medical Insurance Plan _____ Group # _____ Policy # _____

Parent's Signature: _____ Date: _____

Allergies, Special Needs, Existing/Previous Illnesses or injuries, or Hospitalizations, during the past 12mo.
: _____



Childs Name: _____

4 THINGS NEEDED FROM YOUR PHYSICIAN:

THIS PART NEEDS TO BE SIGNED BY YOUR DOCTOR:

1. **MEDICAL RELEASE** for _____ (child's name)

The above named child has been examined by a physician and found to be free of infectious diseases and able to participate in group activities at Little Lighthouse Preschool.

*Doctor's Signature _____

*Doctor's Printed Name _____

THESE RECORDS CAN BE FAXED BY YOUR DOCTOR:

2. **Shot Records:**

Please attach a copy of your child's current shot records to this form.

Can be FAXED to us at 214-544-6967

3. **Hearing and Vision Requirements for 4 & 5 year olds:**

Please attach a copy of child's Hearing and Vision results from physician

Can be FAXED to us at 214-544-6967

4. **DOCTOR DOCUMENTED ALLERGIES:** Please see office for required form if applicable



ALLERGY EMERGENCY PLAN

This plan must be signed and dated by your child's Health Care Professional

Child's name: _____ Date of Birth: _____

Doctor: _____

Address: _____

Phone: _____ Fax: _____

Please complete one form for EACH KNOWN ALLERGY

Child is allergic to: _____

Possible Symptoms if exposed are: _____

Specific Steps to take if child has an allergic reaction: _____

By signing below, the parent or guardian of this child gives Little Lighthouse Preschool permission to post the child's allergy for staff and personnel.

Dr. Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Center Director Signature: _____ Date: _____

For licensed center to use:

_____ *Allergy plan had been posted in classroom, white board and first aid area*

_____ *Allergy plan has been included in emergency evacuation binder*