



Student Emergency Form

2021-2022 School Year

Participant Name	Gender	Birthdate
Name For Child's Cubby Tag		Phonetic Spelling (if applicable)

Address:		
City:	State:	Zip Code:

Please check ALL classes your child will be attending this school year:

- | | | |
|---|--|--|
| <input type="checkbox"/> Young 3s M/W | <input type="checkbox"/> Young 3s T/TH | <input type="checkbox"/> 3s M/W/F Mornings |
| <input type="checkbox"/> 3s M/W/F Afternoons | <input type="checkbox"/> 3s T/TH Mornings | <input type="checkbox"/> 3s T/TH Afternoons |
| <input type="checkbox"/> 4s M/W/F Mornings - RC | <input type="checkbox"/> 4s M/W/F Afternoons - RC | <input type="checkbox"/> 4s M/W/F Mornings - JI |
| <input type="checkbox"/> 4s M/W/F Afternoons - JI | <input type="checkbox"/> Pre-K Enrichment Mornings | <input type="checkbox"/> Pre-K Enrichment Afternoons |

Parent/Guardian Information

Mother/Guardian 1 Information	Name:	
Primary Phone:	Secondary Phone:	
Email:	<input type="checkbox"/> Check box if authorized to pick up child	

Father/Guardian 2 Information	Name:	
Primary Phone:	Secondary Phone:	
Email:	<input type="checkbox"/> Check box if authorized to pick up child	

Emergency Contact

Emergency Contacts must be persons other than parents/guardians listed above

Name:	Relationship to Child:
Primary Phone:	<input type="checkbox"/> Check box if authorized to pick up child

Name:	Relationship to Child:
Primary Phone:	<input type="checkbox"/> Check box if authorized to pick up child

Name:	Relationship to Child:
Primary Phone:	<input type="checkbox"/> Check box if authorized to pick up child

Authorized Pickup Information

If any additional people are authorized to pick up your child, please complete this section. (Optional)

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Medical & Health History

Please check all that apply. Include specifics where applicable.

Illnesses	Allergies – include specifics	Others/Special Needs
<input type="checkbox"/> Heart defect/disease <input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Bleeding/Clotting Disorders <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Seizures* Please use space below to specify type and frequency of the seizures: <input type="checkbox"/> Other* Please use the space below to specify:	<input type="checkbox"/> Insect Bites/Stings <input type="checkbox"/> Pollen <input type="checkbox"/> Latex <input type="checkbox"/> Medicines/Drugs <input type="checkbox"/> Nuts <input type="checkbox"/> Milk <input type="checkbox"/> Food (specifics) <input type="checkbox"/> Other Please explain type of allergy and severity of reaction: Severe Allergies Does your child require an: <input type="checkbox"/> EpiPen <input type="checkbox"/> Inhaler If yes: <ol style="list-style-type: none"> 1. Parent/Guardian must fill out the <i>Allergy Action Plan Form</i> that can be downloaded at www.glpd.com/preschool 2. Parent/Guardian must supply the Grayslake Park District with the required medication. 	<input type="checkbox"/> Wears Contacts/Glasses <input type="checkbox"/> Fainting <input type="checkbox"/> Ear Problems/Tubes <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Emotional Behaviors <input type="checkbox"/> ADD/ADHD <ul style="list-style-type: none"> <input type="checkbox"/> Medicated <input type="checkbox"/> Non-Medicated <input type="checkbox"/> Nose Bleeds Will your child be taking medication while at school? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <ol style="list-style-type: none"> 1. Parent/Guardian must complete the <i>Permission to Dispense Medication Form & Waiver</i> that can be downloaded at www.glpd.com/preschool 2. Parent/Guardian must supply the Grayslake Park District with the required medication.

Are there any special family circumstances we should be aware of (i.e. divorce, recent move, new baby, etc.)?

I have read and understand the Preschool Parent Handbook and agree to the Grayslake Park District's Behavior Management Policy listed in the handbook.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parent/Guardian Signature: _____	Date: _____
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I give my permission for my child to receive necessary health care and emergency medical treatment. This Student Emergency Form is complete and accurate. I will not allow my child to attend if they become exposed to any contagious disease, or if for any reason, I do not consider my child to be in good physical condition.

Parent/Guardian Signature: _____ Date: _____

Getting To Know Your Child

- Has your child had any previous preschool, daycare or playgroup experience without a parent or caregiver?
 Yes No

If yes, how does your child respond when separating from a parent/caregiver?

- Is English the primary language spoken at home? Yes No

If no, what language is spoken at home? _____

- Can your child's speech be easily understood by non-family members? Yes No

- What words does your child use to ask to use the bathroom? _____

- What is the most frequent reason for discipline? _____

- What discipline technique have you found to be most effective for your child? _____

- How does your child react to discipline? _____

- What are your child's strengths? _____

Which of the following best describes your child? (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Likes to play alone | <input type="checkbox"/> Enjoys stories & books | <input type="checkbox"/> Prefers to play with friends/siblings |
| <input type="checkbox"/> Has imaginary friends | <input type="checkbox"/> Adapts well to adults | <input type="checkbox"/> Cooperates well with others |
| <input type="checkbox"/> Enjoys games & sports | <input type="checkbox"/> Enjoys music & movement | <input type="checkbox"/> Enjoys art & drawing |
| <input type="checkbox"/> Enjoys pets & animals | <input type="checkbox"/> Prefers indoor play | <input type="checkbox"/> Prefers outdoor play |

Check any behaviors your child has:

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Hitting | <input type="checkbox"/> Inability to Focus |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Easily Distracted | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Biting | <input type="checkbox"/> Inability to Follow Directions | <input type="checkbox"/> Apprehensive |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Fearful | <input type="checkbox"/> Short Attention Span |
| <input type="checkbox"/> Other _____ | | |

- If behaviors are checked above, please provide us with information that may be helpful such as, what might trigger the behavior(s) and how you address the behavior(s) with your child?

- What do you expect your child to achieve in preschool?

- Please provide any information that you believe will make your child more comfortable at preschool. Include special interests, favorite toy or game, activities, siblings, pets, etc. _____
