

Emergency Information Form

(Two copies of each page are needed)

Child's Last Name: _____ First Name: _____

Middle Initial: _____ Gender: _____ Date of Birth: ____/____/____

Days Attending: 2 days, M&F/ class only _____ *Classroom: (to be filled in by director)*
2 days, M&F – full time _____ *Infant Room _____*
3 days, T, W, Thur. – full time _____ *Toddler Room _____*
4 days, M, T, W, Thur. – full time _____ *Early Preschool Room _____*
4 days, T, W, Thur. F – full time _____ *Preschool _____*
5 days – full time _____ *Pre-K _____*

Special Schedule Requested _____

Enrolled on: ____ - ____ - ____ Deposit Check # _____ Amount: \$ _____

Start Date: ____ - ____ - ____

Child's Home Address: _____

Child's Home Phone Number: _____

Allergies: _____ EPI Pen Needed: Yes or No

Daily Medications to be given at school: _____

Extra medication needed for emergency supplies: _____

Paperwork needed on file before child may attend:

Forms may be found on web site: mountainsideschool.com. Please print forms off, fill in, and return.

- Application: 1 time when enrolling
- Health History: 1 time when enrolling
- Certificate of Immunization: 1 time when enrolling – update when an immunization is given or
- Certificate Of Exemption
- First page of the parent handbook: 1 time when enrolling
Handbook will be given to parent by teacher or director. First handbook free, additional copies \$10
- Emergency Contact Information: 1 time (2 copies, update if changes are made)
- Billing Policy: Yearly. Tuition is due on the 1st of each month, payable one month in advance.
- Consent for Emergency Treatment: yearly (2 copies)
- Fall Re-Enrollment Form: Form and re-enrollment fee due back by Feb. 14th each year. This form will be passed out by director in January.

Primary Payer #1

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: _____ Email Address: _____

Physical Address: _____

City: _____, State: _____, Zip: _____

Mailing Address if different: _____

City: _____, State: _____, Zip: _____

Relationship to child: _____ Payer S.S. Number: _____ - _____ - _____

Lives with Yes No Emergency Contact #1 & Pick-up _____ Pick-up Only _____

Phone:

- Home: _____ - _____ - _____
- Cell: _____ - _____ - _____
- Work: _____ - _____ - _____ Name of Work Place: _____

Primary Payer #2

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: _____ Email Address: _____

Physical Address: _____

City: _____, State: _____, Zip: _____

Mailing Address if different: _____

City: _____, State: _____, Zip: _____

Relationship to child: _____ Payer S.S. Number: _____ - _____ - _____

Lives with Yes No Emergency Contact #2 & Pick-up _____ Pick-up Only _____

Phone:

- Home: _____ - _____ - _____
- Cell: _____ - _____ - _____
- Work: _____ - _____ - _____ Name of Work Place: _____

Related People / Relationships

The following relationships will be emergency contacts/pick-ups. Please list in order as you would like us to call in the event the above payee's cannot be reached. Please include one out-of-state contact in the event phone lines go down in our state.

If your child is being picked-up by anyone other than a parent, a today slip must be filled out by parent. Staff will request to see I.D. of person picking up.

Person #1

Last Name: _____

First Name: _____ Middle Initial: _____ Gender: _____

Physical Address _____

City: _____, State: _____, Zip: _____

Phone:

- Home: _____ - _____ - _____
- Cell: _____ - _____ - _____
- Work: _____ - _____ - _____ Name of Work Place: _____

Relationship to child: _____

Lives with Emergency Pick-up _____ Pick-up Only _____
 Yes No

Person #2

Last Name: _____

First Name: _____ Middle Initial: _____ Gender: _____

Physical Address _____

City: _____, State: _____, Zip: _____

Phone:

- Home: _____ - _____ - _____
- Cell: _____ - _____ - _____
- Work: _____ - _____ - _____ Name of Work Place: _____

Relationship to child: _____

Lives with Emergency Pick-up _____ Pick-up Only _____
 Yes No

Person #3

Last Name: _____

First Name: _____ Middle Initial: _____ Gender: _____

Physical Address _____

City: _____, State: _____, Zip: _____

Phone:

- Home: _____ - _____ - _____
- Cell: _____ - _____ - _____
- Work: _____ - _____ - _____ Name of Work Place: _____

Relationship to child: _____

Lives with Yes No Emergency Pick-up _____ Pick-up Only _____

Person #4

Last Name: _____

First Name: _____ Middle Initial: _____ Gender: _____

Physical Address _____

City: _____, State: _____, Zip: _____

Phone:

- Home: _____ - _____ - _____
- Cell: _____ - _____ - _____
- Work: _____ - _____ - _____ Name of Work Place: _____

Relationship to child: _____

Lives with Yes No Emergency Pick-up _____ Pick-up Only _____

I hereby give my permission that my child

First Name: _____ Middle Initial: _____

Last Name: _____

Child's Birth-date: _____ - _____ - _____ Child's Social Security Number: _____ - _____ - _____

Be given emergency treatment by a qualified staff member at Mountainside School. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

In the event I cannot be contacted, I further consent to medical, surgical, hospital care, treatment, and procedures to be performed for my child by a licensed physician to safeguard my child's health. I understand that I will be responsible for any billing.

Parent/Parent's Please Print

First Name: _____ Middle Initial: _____

Last Name: _____

Parent Signature _____ Date: __/__/__

Parent/Parent's Please Print

First Name: _____ Middle Initial: _____

Last Name: _____

Parent Signature _____ Date: __/__/__

Physician Information

Last Name: _____ First Name: _____ Gender: _____

Physical Address: _____

City: _____, State: _____, Zip _____

Office Phone Number: _____ - _____ - _____ Preferred Hospital: _____

Medical Insurance Company Name: _____

Medical Insurance Policy Number: _____

Date of Last Physical: ____/____/____ (must be yearly when attending child care)

Dentist Information

Last Name: _____ First Name: _____ Gender: _____

Office Phone Number: _____ - _____ - _____ Name of Office: _____

Physical Address: _____

City: _____, State: _____, Zip _____

Dental Insurance Company Name: _____

Dental Insurance Policy Number: _____

Date of last dental appointment: ____/____/____

Information on these forms may change. Please update it immediately with your child's teacher and with the director.

Below information to be filled out by director when a child is leaving Mountainside.

Child will be leaving Mountainside on ____/____/____.

Reason for leaving: _____.