EMERGENCY & MEDICAL POWER OF ATTORNEY FORM

CHARLESTON BAPTIST TEMPLE'S

NEW BEGINNINGS PRESCHOOL

2023 – 2024 SCHOOL YEAR

Child's info:

Child's name: _____

Address: _____

City: _____ State: _____ Zip: _____

Child's date of birth: _____ Home phone: _____

Guardian info:

Mother's name _____

Address: _____

Phone: home: _____ cell: _____ business: _____

Place of employment: _____ May we call you at work? _____

Father's name: _____

Address: _____

Phone: home: _____ cell: _____ business: _____

Place of employment: _____ May we call you at work? _____

Custodial parent(s): _____

Child's doctor: _____ Phone: _____

Child's dentist: _____ Phone: _____

List any allergies, drug reactions, or medical conditions that your child has: _____

_____

(over)

Emergency contact people (in the event parents cannot be reached):

Name: _____ phone: (H): _____ (C): _____

Name: _____ phone: (H): _____ (C): _____

Name of anyone who may pick up your child from school:

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

May New Beginnings Preschool photograph your child? _____

May these photos (without name) be used on the preschool website at www.baptisttemplepreschool.com and the New Beginnings Preschool Facebook page? _____

Medical history:

List any childhood diseases your child has had: _____

Immunization record (please circle): HEP B 1 2 3 DTaP 1 2 3 4 HIB 1 2 3 4 MMR

IPV/Polio 1 2 3 HEP A 1 2 PCV/Prevnar Varicella Rotavirus Influenza

Insurance company & address: _____

Insurance number: _____

Medical Power of Attorney:

I authorize that any staff member of New Beginnings Preschool may order any and all forms of emergency medical treatment for my child as a result of injury or illness while at the New Beginnings Preschool program, if neither I nor the emergency contact people listed above can be reached. This treatment may include x-rays, tests, and treatment. I authorize the staff to provide or arrange necessary related transportation for my child. I also agree that if medical treatment is administered, I and/or my insurer will be responsible for the costs of such treatments.

I agree that all the information on this form is accurate and hereby give my permission accordingly:

Parent signature: _____ Date: _____