

Lamb of God Preschool Ministry
New Student Enrollment & Emergency Information
972-539-0055 Fax: 972-539-8194
preschool@log.org

Child's Name: _____ **Child's birth date:** _____
Last First Middle

Child is commonly called: _____ **Sex:** _____ Female _____ Male

Home Address: _____
Street City Zip

Home Phone: _____ **Father's Cell:** _____ **Mother's Cell:** _____
Area code + Number Including Cell Provider Including Cell Provider

Father: _____ **D.L.#:** _____ (State issued)
Last First

Mother: _____ **D.L.#:** _____ (State issued)
Last First

PARENT'S: MARITAL STATUS _____ Married _____ Separated _____ Divorced* _____ Single parent _____ Widowed
*If divorced, please give name and address of non-custodial parent:

Name _____ Phone _____

Address _____

State whether this person has permission to claim child at school _____

Father's E-Mail: _____ Employer: _____ Work Phone: _____

Mother's E-Mail: _____ Employer: _____ Work Phone: _____

Family Religious Preference: _____ Membership: _____ N/A _____

Primary Language Spoken in home: _____ Names & Ages of Siblings: _____

Emergency Contacts

I give Lamb of God Early Childhood Ministry Preschool permission to release my child to and/or permission to contact the following people in case of an emergency.

Name _____ **Phone #** _____

Address _____ **Relationship to child** _____

Name _____ **Phone #** _____

Address _____ **Relationship to child** _____

Name _____ **Phone #** _____

Address _____ **Relationship to child** _____

I agree that all information listed above is honest and accurate as of the date listed below. I understand the registration/supply fee is non-refundable. Failure to pay fees by due dates listed may result in your child's spot being released. Please keep in mind that each class has a student minimum enrollment requirement. Requests to change enrollment or class may not be honored after July 1st.

LOG Preschool has permission to use photos of my child on school website or other media sources. In addition, all students will be included in the School Handbook/Directory. To opt out, please initial here: Photos _____ Handbook/Directory _____

Parent's Signature: _____ **Date:** _____

For Office Use Only: RW _____ Date _____ By _____

**Lamb of God Lutheran Church Preschool Ministry
New Student Enrollment & Emergency Information**

972-539-0055 Fax: 972-539-8194

preschool@log.org

**LIABILITY RELEASE WITH PARENTAL CONSENT
FOR MEDICAL/EMERGENCY
TREATMENT AND TRANSPORTATION**

CHILD'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ PHONE NUMBER _____

The undersigned(s) being the lawful parent(s) and/or guardian(s) of the above child, hereby consent to the participation by the child in all Preschool activities conducted by Lamb of God Lutheran Church Preschool Ministry and to the participation of the child in all events related to these activities.

The undersigned hereby further authorize(s) staff and employees of Lamb of God Lutheran Church Preschool Ministry to provide for, approve and authorize emergency health care at any hospital, emergency room, doctor's office or other institution, employ any physicians, dentists, nurses or other person whose services may be needed for such health care, review and if necessary disclose the contents of any medical records, execute any consent form required by medical, dental or other health authorities incident to the provision of medical, surgical, or dental care to the child. Health care shall include, but not be limited to the administration of anesthesia, x-ray, examination, surgery, diagnostic and other procedures.

The undersigned(s) hereby further authorize(s) emergency transportation by either preschool personnel or if necessary by ambulance or other emergency vehicle.

If there is no medical emergency, the preschool staff will first use reasonable efforts to contact the parent(s) and /or guardian(s) before administering or authorizing any treatment.

Notwithstanding other provisions in this consent form, Lamb of God Lutheran Church Preschool Ministry shall not have the authority to withhold or withdraw life-sustaining procedures for the child.

The Preschool is well child-proofed and the children are consistently well supervised. However, accidents do happen. The undersigned(s) assume(s) all risk of injury or harm to the child associated with participation in the preschool and agree(s) to release, indemnify, defend and forever discharge Lamb of God Lutheran Church Preschool Ministry and its staff and employees of and from all liability, claims, demands, damages, costs, expenses, actions and causes of action in respect to death, injury, loss or damage to the child, or by the child, howsoever caused, arising or to arise by reason of or during the child's participation in the preschool.

Signature of Parent/Guardian

Date

Lamb of God Preschool Ministry

Student Health Statement

1401 Cross Timbers Road, Flower Mound, TX 75028
972-539-0055 Fax: 972-539-8194

To be completed by parent:

Child's Name: _____ Sex: ___M ___F Child's Birthdate: _____

List any allergies:

Does the allergy cause a reaction that requires medical attention? ___ No ___ Yes ***If yes, you must complete an Allergy Action Plan and Permission for Medication Form.***

List any recent illness:

List any chronic illness/condition:

If child has been hospitalized in past 12 months, please describe/explain:

List any conditions for which child may require special treatment:

Note: If medications are to be administered during school hours, an ***Allergy Action Plan and Permission for Medication Form*** must be filled out and on file in the school office. All medications **must be** in the original container and labeled for the listed child only.

Child's Physician's Name: _____

Physician's Address: _____

Phone Number(s): _____

Authorization for Emergency Medical Care

In the event that the child named above requires emergency medical care and parents cannot be reached, I hereby authorize Lamb of God Preschool Ministry to secure such care as may be required at the nearest emergency medical facility.

Parent Signature

Date

Lamb of God Preschool Ministry
Physician's Statement
1401 Cross Timbers Road, Flower Mound, TX 75028
972-539-0055 Fax: 972-539-8194

Physician's Examination

To be completed by physician:

Child's Name: _____

Date of Exam: _____ Birthdate: _____

Hearing Screening: _____ Vision Screening: _____
(Required by Texas Dept. of State Health Services for children 4yrs. and up attending private or public school.)

Other Tests: _____

Allergies or Medical Conditions: _____

**I have examined the child named above and find that he/she IS/IS NOT able to participate in a preschool program.
I have examined the immunization record and attest that it is a true and accurate listing.**

Physician's Signature: _____

Date: _____

Physician's Address _____

Phone: _____

Please attach a current copy of the child's immunization record to this form.

**Lamb of God Preschool Ministry
Allergy Action Plan and
Permission for Medication Form**

1401 Cross Timbers Road, Flower Mound, TX 75028
972-539-0055 Fax: 972-539-8194

This form must be completed and returned to the Preschool office in order for any medication (including Epi-Pen) to be administered to your child.

Child's Name _____ Birthdate _____

Allergy or Medical Condition:

Briefly describe what happens to your child during an allergic reaction:

Please explain treatment plan if your child develops an allergic reaction/medical condition:

- _____
- _____
- _____
- _____
- _____

I authorize Lamb of God Preschool Ministry to administer the medication listed below to my child:

Medication must be in its Original Container with Child's Name clearly noted on label.

Name of Medication

Dosage

Name of Medication

Dosage

Name of Medication

Dosage

Name of Medication

Dosage

I understand and agree that Lamb of God Preschool Ministry and its employees will not be held liable in so far as they administer medical care in conformance with the information provided on my child's Allergy Action Plan and Permission for Medication form. I understand that the school and its employees will use reasonable care in doing so.

Signature of Parent

Date

Signature of Physician

Date

