

**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 Phone:** \_\_\_\_\_  
Area code + Number

**Home Address:** \_\_\_\_\_  
Street City Zip

**Parent Information: Marital Status** \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ \*Divorced \_\_\_\_\_ Single parent \_\_\_\_\_ Widowed  
*\*If divorced, please give name and address of non-custodial parent.*

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

Cell Phone Number: \_\_\_\_\_ Cell Phone Provider: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Area code + Number

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Cell Phone Number: \_\_\_\_\_ Cell Phone Provider: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Area code + Number

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**\*Non-Custodial Parent:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Last First Area code + Number

\*Address: \_\_\_\_\_

\*State whether this person has permission to claim child at school \_\_\_\_\_ Yes \_\_\_\_\_ No

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 my child's spot being released. Each class has a student minimum enrollment requirement. Requests to change enrollment or class may not be honored after July 1<sup>st</sup>. I understand that the Parent Policy Handbook and School Calendar are both located on the school website: www.log.org. Images of students may appear on the LOG Preschool website or other sources. All students will be included in the Preschool Handbook/Directory. To opt out, please initial here: Website/Social Media Photos \_\_\_\_\_ Handbook/Directory \_\_\_\_\_

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

For Office Use Only: RW \_\_\_\_\_

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

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**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:

\_\_\_\_\_

Has your child travelled outside of the United States within the last 6 months? \_\_\_ No \_\_\_ Yes ***If yes, you must provide Statement of Health and Well Being from a certified Physician.***

\_\_\_\_\_

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  
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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:

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

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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**

