FREEPORT CHILD DEVELOPMENT LAB

FAMILY AND CONSUMER SCIENCE DEPARTMENT

FREEPORT AREA SENIOR HIGH SCHOOL

625 South Pike Road

Sarver, PA 16055

724-295-5143 or 724-295-5144 ext. 547

E-MAIL: crighton@freeport.k12.pa.us

SOCIAL INFORMATION FORM

NAME OF CHILD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE\_\_\_\_\_\_\_\_\_\_\_

NAME USUALLY CALLED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ I DO NOT WANT MY CHILD VIDEOTAPED OR PHOTOGRAPHED FOR PUBLICATION.

\_\_\_\_\_\_ I DO NOT WANT MY ADDRESS AND TELEPHONE NUMBER ON THE LIST OF ALL THE CHILDREN

ATTENDING THIS SESSION OF NURSERY SCHOOL.

1. Are there many young children in your neighborhood?
2. How old are your child’s playmates?
3. Has your child ever been away from you overnight? How does this affect your child?
4. Is your child accustomed to being with babysitters, grandparents, etc?
5. What activities does your child most enjoy?
6. What is his/her favorite time of day?
7. Do you have any pets at home?
8. Does your child help share the responsibilities for this pet?
9. Does your child have any special interest?
10. Is there any particular thing which frightens your child? (Please be specific)
11. When dealing with these particular fears, what do you recommend?
12. What does your child do what he/she becomes upset?
13. Under what circumstances does your child most easily become upset?
14. What helps reassure your child when he/she becomes upset?
15. Do you have any suggestions to help make your child feel comfortable in Nursery School?

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MEDICAL INFORMATION FORM

NAME OF CHILD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PLACE OF EMPLOYMENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 WORK HOURS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 BUSINESS PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PLACE OF EMPLOYMENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 WORK HOURS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 BUSINESS PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN THE EVENT OF AN ACCIDENT/ILLNESS IN THE CHILD DEVELOPMENT LAB, AND WE ARE UNABLE TO CONTACT EITHER PARENT AT THE ABOVE PHONE NUMBERS, PLEASE CONTACT:

1. RELATIVE OR NEIGHBOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. RELATIVE OR NEIGHBOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN CASE OF EMERGENCY AND IT IS NECESSARY TO CALL A DOCTOR OR DENTIST, CONTACT:

FAMILY PHYSICIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY DENTIST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN THE EVENT OF AN EMERGENCY, TO WHICH LOCAL HOSPITAL WOULD YOU PREFER YOUR CHILD TO BE SENT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS OR CONCERNS? IF SO, WHAT ARE THEY?

DAILY MEDICATIONS TAKEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I HEREBY GIVE MY PERMISSION TO AN AUTHORIZED SCHOOL OFFICAL TO OBTAIN PROFESSIONAL MEDICAL ATTENTION FOR MY SON/DAUGHTER IN CASE OF INJURY OR ILLNESS.

DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PARENT’S OR GUARDIAN’S SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunization Record for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (name of child)

Age of child as of October 11, 2017\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaccine Date(s) Given

DTP

(Diphtheria, Tetanus, Pertussis)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (3 DPT shots by 6 months; 4th diphtheria and tetanus shot by 4th birthday)

Hepatitus B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(3 doses)

Measles, Mumps, Rubella\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(1 dose of Mumps and Rubella) (2 doses for Measles)

Polio\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(3 vaccines)

Varicella\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(1 immunization or documentation of the disease- Chicken Pox)

A child may have 1.) Medical exemption signed by a doctor or 2.) A religious/philosophical exemption signed by a parent. If there is an exemption, the child may be excluded from school if any of the above diseases are present in school.

Please list any FOOD OR OTHER ALLERGIES:

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WAIVER OF SCHOOL ACCIDENT INSURANCE

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, GIVE MY PERMISSION FOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO PARTICIPATE IN THE CHILD DEVELOPMENT LAB PROGRAM. WE HAVE INSURANCE AND FEEL THAT OUR ACCIDENT INSURANCE AND HOSPITALIZTION ARE ADEQUATE TO MEET ANY EXPENSES. WE UNDERSTAND THAT UNDER NO CIRCUMSTANCES IS THE FREEPORT AREA SCHOOL DISTRICT RESPONSIBLE OR LIABLE FOR ANY INJURIES SUSTAINED BY MY CHILD DUE TO HIS/HER PARTICIPATION IN THE CHILD DEVELOPMENT LAB PROGRAM OR FOR ANY BILL OR EXPENSES AS A RESULT OF ANY SUCH INJURY.

PLEASE SUBMIT INSURANCE INFORMATION IN THE SPACES PROVIDED. THANK YOU.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Insurance Company Name Local Agent

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Policy Number Expiration Date

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent’s or Guardian’s Signature