FCA PRESCHOOL STUDENT INFORMATION CARD

Date_____ Age _____ Date of Birth _____ ☐ Male ☐ Female

Student Name _____
(Last) (First) (Middle)

Nationality: ☐ Asian/Pacific ☐ Caucasian-American ☐ Hispanic ☐ African-American ☐ American Indian ☐ Foreign ☐ Unknown

Home Address _____
(Street) (City) (State) (Zip Code)

Father's Name _____ Church Attending _____
(Last) (First) (Middle)

Father's Address _____ Home Number _____ _____ _____
(Street) (City) (State) (Zip Code)

Marital Status: ☐ Single ☐ Married ☐ Widower ☐ Divorced ☐ Separated Cell Number _____ _____ _____

Father's Occupation _____ Father's Employer _____

Employer's Tel. Number_____ _____ _____ Employer's Address _____
(Street) (City) (State) (Zip Code)

Mother's Name _____ Church Attending _____
(Last) (First) (Middle)

Mother's Address _____ Home Number _____ _____ _____
(Street) (City) (State) (Zip Code)

Marital Status: ☐ Single ☐ Married ☐ Widower ☐ Divorced ☐ Separated Cell Number _____ _____ _____

Mother's Occupation _____ Mother's Employer _____

Employer's Tel. Number_____ _____ _____ Employer's Address _____
(Street) (City) (State) (Zip Code)

List names and ages of other children in family, including those attending this school: _____

_____

(Please turn over and complete the other side.)

(Parent/Guardian Signature) (Parent/Guardian Signature)

EMERGENCY INFORMATION: (LIST TWO ADULTS TO CONTACT IN CASE OF EMERGENCY)

(1) Name _____ Telephone/Ext. _____ / _____

(2) Name _____ Telephone/Ext. _____ / _____

Any additional emergency numbers (Cell, Beeper, Etc.) _____

Grandparents: (1) Name _____ (2) _____

Address _____ _____

Telephone _____ _____

Child's Physician _____ Telephone Number _____ _____

Hospital Preference _____ Telephone Number _____ _____

Child's Dentist _____ Telephone Number _____ _____

Medical Insurance Company _____ Policy Number _____

Significant Health Problems/Illnesses _____

Medications _____ Allergies _____

Vision Problems _____ Hearing Problems _____ Scoliosis _____

In case of emergency, do we have permission to take your child to a qualified medical doctor, dentist, or hospital if necessary? ☐ Yes ☐ No

_____

The undersigned, as parents(s)/guardian(s) of _____ do hereby consent to any and all medical/surgical treatments, anesthesia, and operations which may be deemed advisable by any qualified medical doctor selected by the agents of Family Christian Academy. The intention hereof is to grant authority to administer and to perform all and singularly any examinations, treatments, anesthetics, operations, and diagnostic procedures which may now, or during the course of the patient's care, be deemed advisable or necessary by any qualified medical doctor.

(Parent/Guardian Signature) (Parent/Guardian Signature)