

Murrieta Ranch Pre-School & Kindergarten

Identification and Emergency Information

Childs Name _____ M or F _____ DOB _____
 Address _____
 City & State _____ Zip Code _____
 Family's Primary Email Address _____

Indicate a #1 or #2 in left hand box next to parent name, which parent to notify first in case of an Emergency)

<input type="checkbox"/>	Mother's Name _____	Daytime#	()	
	Place of Employment _____	Bus#	()	
	Last 4 digits SS# _____	Cell#	()	
		Home #	()	
<input type="checkbox"/>	Father's Name _____	Daytime#	()	
	Place of Employment _____	Bus#	()	
	Last 4 digits SS# _____	Cell#	()	
		Home #	()	

Person to call in case of emergency or illness if parents can't be reached

	Name	Relationship	()	Phone #
I	_____	_____	()	_____
II	_____	_____	()	_____
III	_____	_____	()	_____

Physician To Be Called In An Emergency

Name _____ Phone # () _____
 Address _____

(*If physician cannot be reached, what action should be taken?*)

Hospital _____
 Other _____

Parents Signature _____ Date _____

Murrieta Ranch Pre-School & Kindergarten Authorization To Pick Up and Release Information

Child's Name _____ Birthdate _____
 Allergies _____
 Reaction _____ Epi Pen? Yes or No

In accordance with the state law we must have on file the names and telephone numbers of individuals permitted to drop off or pick-up your child from school. If someone arrives to pick up your child and we have not been introduced or do not have written permission from you to pick them up we cannot allow your child to leave with them. We must also ask the person to show us photo identification.

Thank you for your cooperation

Names Of Persons Authorized To Take Child From School

*****PLEASE INCLUDE MOM AND DAD FIRST ON THIS LIST*****

Name	Relationship	Phone #

I do understand that if the name does not appear on this list, and if the person does not have photo identification my child will not be released from school.

Parent's Signature	Date

<u>OFFICE USE ONLY:</u>	Room # & Days	
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INLAND VALLEY, LOMA LINDA or RANCHO SPRINGS REGIONAL MEDICAL CENTER

Child's Name _____ Date of birth _____

Home address _____

Date of last tetanus shot _____ Allergies _____

Person responsible for bill _____

Address _____

Employer _____ Phone () _____
Company

Address _____

Occupation _____

Insurance _____
Company name Policy holder Policy #

Medical # _____ Medicare# _____

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

Since minors cannot receive emergency treatment without the consent of a parent or guardian, it is suggested that anyone with children under the age of 18 have treatment authorization forms placed on file at the hospital. (I) (we) the undersigned, parent(s) of _____, a minor, do hereby authorize Murrieta Ranch Pre-School as agents for the undersigned to consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of Inland Valley Regional Medical Center, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of my (our) aforesaid agent(s) in the exercise of his best judgment may deem necessary.

This authorization shall remain in effect until July 10, 2021 unless revoked by written request. One parent/guardian signature needed.

Mother _____ Witness _____

Father _____ Witness _____

Legal Guardian _____ Witness _____