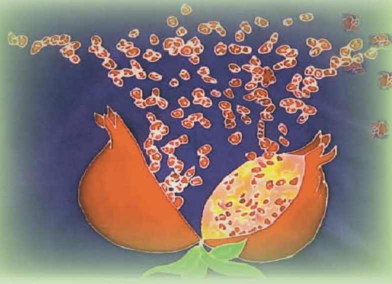

Pomegranate

Preschool for the Arts

Enrollment and Authorization Form

Name of Child: ____

Nickname: ______________________ Birth Date: ___/___/_____ Age at entry: _______

Allergy Alert: Does your child have allergies? ___ Yes ___ No

To what? ____

(List medicines and foods here, and provide details, if needed, on page 3)

Parent(s) or Guardian(s) **Contact Information:**

1. Name: ________________________________ Relationship: _____________________

   Mailing Address: __________________________ Home Phone #: ___________________

   Street Address: ___________________________ Cell Phone #: ____________________

   City / State / Zip: _________________________ Email Address: ___________________

   Employer: ______________________________ Work Hours: ______________________

   Worksite Location: ______________________ Work Phone #: ____________________

---

2. Name: ________________________________ Relationship: _____________________

   Mailing Address: __________________________ Home Phone #: ___________________

   Street Address: ___________________________ Cell Phone #: ____________________

   City / State / Zip: _________________________ Email Address: ___________________

   Employer: ______________________________ Work Hours: ______________________

   Worksite Location: ______________________ Work Phone #: ____________________

Other children in the household:

Name: __________________________________ Age: _________ DOB________

Name: __________________________________ Age: _________ DOB________

Name: __________________________________ Age: _________ DOB________

Has your child had previous experience in pre-school? _____ Yes _____ No

If yes, where? ____ How long? _____________

Reason for change? ____

____

How did you hear about our program? ____

Please list any information concerning your child which will assist us in providing the best care for your child:

Play: ____

____

Eating habits & schedule: ____

Fears: ____

Likes / dislikes: ____

____

Special words & their meanings: ____

____

Do you have any concerns we should be aware of? __________________________________

____

What types of allergies or other health problems does your child have, and what do we need to know to provide the best possible care? Do these restrict your child's activities? ______________________________

____

We always try to contact parents first. However, we are required to have an emergency contact other than parents. These people are also authorized to pick up your child from the facility. We will ask them for picture ID to verify their identity.

1. Name: ______________________________________ Relationship: _____________________

   Phone #1: ____________________________ Phone #2: ______________________________

2. Name: ______________________________________ Relationship: _____________________

   Phone #1: ____________________________ Phone #2: ______________________________

3. Name: ______________________________________ Relationship: _____________________

   Phone #1: ____________________________ Phone #2: ______________________________

Medical Provider: _________________________________ Location: ________________________

Phone #1: ____________________________ Phone #2: ______________________________

Insurance Provider: _______________________________ Group #: _________________________

Dentist: ____ Location: ________________________

Phone #1: ____________________________ Phone #2: ______________________________

My signature gives permission for the following:

In an emergency, I hereby authorize a representative of Temple Emek Shalom, 1800 E. Main Street, Ashland, Oregon 97520 [541] 488-2909, to call an ambulance or to take my child to any available physician or hospital, at my expense, and to obtain medical treatment for my child. In most emergencies, 911 will be called, and the child be transported to Ashland Community Hospital and seen by the emergency medical physician on call. (Parents are always notified as soon as possible.)

I authorize a representative of Temple Emek Shalom to give non-prescription medication as indicated on the container, including sunscreen, Benadryl and antibacterial first aid cream, unless otherwise indicated in the allergies section above. Syrup of ipecac may be administered if deemed necessary by the poison control operator.

• I give permission for my child's photograph, without the name, to be used on the Pomegranate website (please initial): ________

Print Parent / Guardian Name: ____

Signature: ____

Date: ____/_____/__________

FOR OFFICE USE ONLY:

Deposit Received _____	Date Received ________
Materials Fee Received _____	Date Received ________
Immunization Material Received ___	Date Received ________